MESSAGE FROM THE EXECUTIVE DIRECTOR

During the past thirteen years, the workers' compensation system in Massachusetts has continued to bear fruit from the many successful changes made during the 1991 Reform Act. Following this period of reform, the number of cases filed at the Department of Industrial Accidents (DIA) has decreased by 64%. Employee claims, which account for 72% of the total cases filed at the DIA, have decreased by 45% since 1991. The emphasis placed on safety by employers and insurers in the Commonwealth should also be recognized for creating a safer work environment. For the past decade, Massachusetts injury and illness incidence rates have ranked the lowest amongst all New England states and have consistently remained below the National average.

Fiscal Year 2004 can best be described as a year of cautious consideration in reviewing workers' compensation legislation. Of the 43 workers' compensation related bills that were filed by the Legislature, only one bill regarding the judicial appointments of the Industrial Accident Board was passed into law. The Advisory Council commends Chairman Hart and Chairman Rodrigues of the Joint Committee of Commerce & Labor, along with Representatives Cabral and Koczera, for working collectively to pass House Bill 4465. This new law will help alleviate congestion in the judicial appointment process, thereby, decreasing costly and unnecessary delays to injured workers as they proceed through the Dispute Resolution System.

As we look forward to 2005, the Advisory Council will place emphasis on employer fraud initiatives, such as increasing the penalties on those employers who fail to purchase a workers' compensation policy or intentionally misclassify their workers. The "Station" nightclub fire that occurred in the winter of 2003 compelled the Rhode Island Legislature to toughen the consequences on employers operating without workers' compensation insurance. In 2005, the Massachusetts Legislature should also carefully examine the adequacy of the current schedule of fines and penalties to deter employers from violating the insurance mandate.

On behalf of the Advisory Council, I am pleased to present our readers with our Fiscal Year 2004 Annual Report: The State of the Massachusetts Workers' Compensation System. The Advisory Council hopes that this report will serve as a blueprint for identifying areas within the workers' compensation system that can be improved upon. Any effort to amend the workers' compensation system must be carefully scrutinized to ensure that changes to the statute will build upon the successful aspects of the system, benefiting both injured workers and employers.

Thank you.

Andrew S. Burton
WCAC Executive Director

THE STATE OF THE MASSACHUSETTS WORKERS' COMPENSATION SYSTEM

FISCAL YEAR 2004 ANNUAL REPORT

MASSACHUSETTS WORKERS' COMPENSATION ADVISORY COUNCIL

ADVISORY COUNCIL MEMBERS:

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Paul Byrne, *Vice-Chair *(M.B.T.A. Police Association)*
***Robert Banks** *(J.A.C. Iron Workers, Local 7)*
***Jeanne-Marie Boylan** *(Boston Sand & Gravel Company)*
J. Bruce Cochrane *(Cochrane and Porter Insurance Agency)*
***Edmund C. Corcoran, Jr.** *(Raytheon)*
Carol Falcone *(Falcone Associates)*
***Antonio Frias** *(S & F Concrete Contractors, Inc.)*
***Mickey Long** *(AFL - CIO)*
Kenneth J. Paradis, Jr. *(Crowe, Paradis, & Albren, LLP)*
***John A. Pulgini** *(Labourers Union, Local 223)*

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Jane C. Edmonds *(Director, Department of Workforce Development)*
Barbara B. Berke *(Director, Department of Business & Technology)*

STAFF:

Andrew S. Burton *(Executive Director)*
Evelyn N. Flanagan *(Chief Researcher)*
Ann M. Helgran *(Research Analyst)*
**Voting Member*

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ADVISORY COUNCIL

The Massachusetts Workers' Compensation Advisory Council was created by the Massachusetts General Court on December 10, 1985, with the passage of Chapter 572 of the Acts of 1985. The function of the Council is to monitor, recommend, give testimony, and report on all aspects of the workers' compensation system, except the adjudication of particular claims or complaints. The Council also conducts studies on various aspects of the workers' compensation system and reports its findings to key legislative and administrative officials.

Pursuant to the Act, the Advisory Council is mandated to issue an annual report evaluating the operations of the Division of Industrial Accidents (DIA) and the state of the Massachusetts workers' compensation system. In addition, members are required to review the annual operating budget of the DIA and submit an independent recommendation when necessary. The Council also reviews the insurance rate filing and participates in insurance rate hearings.

The Advisory Council is comprised of sixteen members that are appointed by the Governor for five-year terms. The membership consists of: five employee representatives (each of whom is a member of a duly recognized and independent employee organization); five employer representatives (representing manufacturing classifications, small businesses, contracting classifications, and self-insured businesses); one representative of the workers' compensation claimant's bar; one representative of the insurance industry; one representative of the medical providers; and one representative of vocational rehabilitation providers. The Director of the Department of Labor & Workforce Development and the Director of the Department of Economic Development serve as ex-officio members.

The voting members of the Council are comprised of the employee and employer representatives and cannot take action without at least seven affirmative votes. The Council's chair and vice-chair rotate between an employee representative and an employer representative.

The Advisory Council customarily meets on the second Wednesday of each month at 9:00 a.m. at the Division of Industrial Accidents, 600 Washington Street, 7th Floor Conference Room, Boston, Massachusetts.

Meetings are open to the general public pursuant to the Commonwealth's open meeting laws (M.G.L. c.30A, §11(a)).

Advisory Council Studies

The Advisory Council's studies are available for review Monday through Friday, 9:00 a.m. - 5:00 p.m. at the Massachusetts State Library, State House, Room 341, Boston, Massachusetts, 02133, or by appointment at the office of the Advisory Council, 600 Washington Street, 6th Floor, Boston, Massachusetts (617) 727-4900 ext. 378.

For further information about the Massachusetts Workers' Compensation Advisory Council, visit our web page at: **http://www.mass.gov/wcac/**.

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FISCAL YEAR 2004 IN REVIEW

During fiscal year 2004, the Division of Industrial Accidents (DIA) experienced a slight decrease in the number of workers' compensation cases filed. Since the enactment of the Workers' Compensation Reform Act of 1991, the number of cases filed at the DIA has decreased by 64%. Employee claims, which account for 72% of the total cases filed, decreased by 1,730 cases in the fiscal year and have decreased by 45% since fiscal year 1991. Insurers requests for discontinuance, which account for 15% of the total cases, decreased slightly by 271 cases in fiscal year 2004 and have decreased by 77% since the 1991 Reform Act.

In July of 2003, the Advisory Council reviewed workers' compensation legislation that had been filed during the 2003-2004 Legislative Session. As a result of this review, the Advisory Council voted to endorse House Bill 2924 (judicial terms), House Bill 2380 (judicial code of conduct), House Bill 2382 (scar-based disfigurement), House Bill 2205 (civil action against employers) and Senate Bill 1705 (debarment of contractors from public bidding). On July 24, 2004, the Advisory Council testified at a hearing before the Joint Committee on Commerce & Labor to express support for the passage of these workers' compensation bills.

On August 29, 2003, the Commissioner of Insurance issued a rate decision that reduced average workers' compensation rates by 4% from 2001-2002 rate levels. This rate decision marked the end to a contentious rate process that began in March of 2003 when the Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) submitted a rate filing on behalf of insurers seeking an increase of 10.8% (later revised to 8.6%) on average rates. The State Rating Bureau followed with a filing of their own requesting a 9.9% decrease to rates. In an unusual measure, the Attorney General's Office became a party in the rate process and asked the Commissioner of Insurance to reduce average rates by 21.4%.

In September of 2003, the Office of Investigations presented the Advisory Council with an overview of the Stop Work Order Pilot Project that the agency introduced in fiscal year 2003. The DIA implemented this program to improve the billing and collection of Stop Work Orders (SWOs) and to enhance the investigation process. For the past eight years, the Advisory Council has examined various approaches in deterring employers from violating the insurance mandate. The Advisory Council continues to support the DIA's efforts to strengthen the SWO process through internal measures.

In October of 2003, the DIA presented the Advisory Council with a demonstration of the agency's new Oracle Case Management System (CMS). The presentation detailed how the public will be able to submit forms online and how the internal users at the DIA can submit inquiries. When this database conversion began in the fall of 2000, the Advisory Council worked in a unique partnership with the DIA to ensure that adequate funding was available to lay the foundation for the agency's move to e-government. During this two-phase project, the Advisory Council has voted to release approximately $6.1 million from the DIA's Special Reserve Account to pay for the necessary expenses of CMS.

In November of 2003, the Director of the State's Division of Occupational Safety (DOS) came before the Council to share his concern over the lack of legislative funding for the "Annual Survey of Occupational Injuries and Illnesses." Since 1992, DOS has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics, in an effort to collect injury and illness data in a uniform manner. In June of 2004, the Advisory Council formed a subcommittee to discuss possible funding alternatives to save this valuable program. Working with administrative members of the DIA and DOS, the subcommittee agreed that the survey greatly benefited both employers and the DIA's Safety Grant Program. In September of 2004, the DOS received $110,000 in a supplemental budget to cover the expenses associated with the survey.

In December of 2003, the manager of the Workers' Compensation Trust Fund appeared before the Advisory Council to address the policies and procedures of the DIA's Second Injury Fund. Council Members were surprised to learn of the increasing volume of Section 37 cases since 1991 when the standard for eligibility became more strict. At the close of fiscal year 2004, 365 Section 37 claims were paid and settled, amounting to $19,739,158 in payments. Also troubling to the Advisory Council is the fact that a large portion of the Section 37 volume stems from a small group of attorneys who specialize in these cases.

Also in December of 2003, the Workers' Compensation Research Institute (WCRI) released a study that assesses injury recovery, return to work and access to health care in four states. The WCRI study, titled "Outcomes for Injured Workers in California, Massachusetts, Pennsylvania, and Texas," showed workers injured in Massachusetts report better outcomes from their injuries versus those injured in the other states surveyed. Among the findings, better than four out of five injured workers in Massachusetts were somewhat or very satisfied with their initial providers and only 11% of those workers surveyed said they wished to change their primary medical provider. The study also reported that the "overwhelming majority" of those surveyed were able to get appointments with their initial and primary medical providers in a timely manner.

On December 18, 2003, Governor Mitt Romney signed Executive Order No. 456, which overhauled the procedures for identifying, screening and nominating candidates for all judicial vacancies. The main objective of the Executive Order was to strengthen the selection process to ensure that all applicants who apply for a judgeship have their qualifications reviewed on merit. The Executive Order requires the Advisory Council to submit its judicial ratings to the Governor's Chief Legal Counsel within one week from the time a candidate's name is transmitted to the Council from the Nominating Panel. If the Advisory Council fails to make a rating within one week from receiving the names, said candidates will receive a "qualified" rating. As a result of the Executive Order, the Advisory Council drafted internal guidelines to ensure that the Council could evaluate and rate the qualifications of judicial candidates in a timely fashion.

On January 12, 2004, members of the Advisory Council met with Representative Michael Rodrigues (House Chairman of the Joint Committee on Commerce & Labor) to discuss the Council's legislative priorities and to answer questions. As a result of this meeting, House Bill 2380 (code of judicial conduct legislation) was amended with language that would subject DIA judges to a Model Code of Conduct endorsed by the American Bar Association. On January 20, 2004, the Joint Committee on Commerce & Labor held an

Executive Session on all workers' compensation legislation before the committee. Although a majority of the bills were placed into "study," twelve bills were "favorably rated" and combined into newly redrafted legislation.

On February 23, 2004, the Advisory Council forwarded a letter to the members of the House Committee on Steering, Policy and Scheduling, stating the Council's endorsement of House Bill 4465. This bill would stagger judicial terms "naturally" by clarifying that newly appointed Administrative Judges (AJs) be appointed to new six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. This bill would also require the Senior Judge to review the performance of newly appointed AJs after their first 2-years of service. Finally, this legislation would require the Senior Judge, the Administrative Judges and Administrative Law Judges to be subject to the Model Code of Judicial Conduct for State Administrative Law Judges, as promulgated by the American Bar Association. In August of 2004, this bill would be signed into law as the only piece of workers' compensation legislation to pass in the 2003-2004 Legislative Session.

On February 24, 2004, the Massachusetts Bar Association released their findings from a statewide survey that attempts to measure how workers' compensation attorneys rate Industrial Accident Board Judges on knowledge, bias, demeanor and other key areas. This year's survey asked two new questions regarding judicial bias. The survey stated that the vast majority of judges at the DIA demonstrate little or no bias toward individuals. In the past, the survey has been used as an evaluation tool by both the Advisory Council and Nominating Panel during the judicial nomination process.

In March of 2004, the Advisory Council held two judicial interview meetings to review the qualifications of 19 outside applicants seeking appointment to the positions of Administrative Judge and Administrative Law Judge. During these meetings, the Council Members also conducted a paper review on the qualifications of nine sitting judges seeking reappointment. On March 26, 2004, the Advisory Council forwarded all 28 judicial recommendations to the Governor's Chief Legal Counsel for review.

In April of 2004, the Advisory Council voted to endorse the Governor's Fiscal Year 2005 Budget Recommendation (House 1) of $19,422,377 to fund the DIA's line-item. At the recommendation of the Advisory Council's Budget Subcommittee, the Council forwarded a letter of endorsement to the House Ways & Means Committee requesting that "not less than $800,000" be expended for the Safety Grant Program. The Advisory Council also expressed support for Outside Section #397 (contained within House 1) which would allow the DIA to suspend or prohibit the issuance or renewal of a driver's license to an employer operating a business in Massachusetts without the requisite workers' compensation insurance.

On April 26, 2004, AFL-CIO workers throughout Massachusetts gathered on City Hall Plaza in a Workers Memorial Day commemoration to honor workers killed and injured on the job in the last year, including servicemen in Iraq. Coinciding with Workers' Memorial Day was the release of a state-wide occupational fatality report sponsored by the Massachusetts AFL-CIO and the Massachusetts Coalition for Occupational Safety and Health. This report titled, "Dying for Work in Massachusetts: The Loss of Life and

Limb in Massachusetts Workplaces," recognizes those workers from the Commonwealth who lost their life on the job.

In May of 2004, the Massachusetts Insurance Federation presented the Council with an overview of a report outlining the potential benefits of moving to a competitive pricing system for workers' compensation insurance in Massachusetts. The report titled, "A Study Evaluating Competitive Pricing for Workers' Compensation Insurance in Massachusetts," was prepared in August of 2003 and details the benefits of competitive pricing systems versus administered pricing systems. The findings in the report support the adoption of a competitive loss cost pricing system as proposed in House Bill 3293.

In June of 2004, the DIA's General Counsel appeared before the Advisory Council to offer a presentation on the agency's new bilingual statewide public awareness campaign that is aimed at educating employers in the Commonwealth about the mandatory requirement to provide workers' compensation insurance. The campaign titled, "Putting Workers First," utilized paid and free media, television and radio public service announcements, and various forms of print media. In conjunction with the campaign, the DIA established a toll-free number (1-877-MASSAFE) to further educate employers and employees on their rights and responsibilities and to allow for the reporting of suspected employers who are violating the law.

CONCERNS & RECOMMENDATIONS

The Advisory Council is mandated by M.G.L. c.23E, §17 to include in its annual report "an evaluation of the operations of the [DIA] along with recommendations for improving the workers' compensation system." In an effort to enhance the workers' compensation system, the Council has identified the following areas of concern and offers its recommendations to address them.

Stiffer Penalties for Uninsured Employers

For the past nine years, the Advisory Council has examined various approaches in deterring employers from violating the workers' compensation mandate. Council Members have agreed that the stop work order (SWO) and fine provisions, which were established in 1987, are not sufficiently punitive to deter employers from violating the mandate to obtain workers' compensation insurance coverage. A flat fine of $100 per day may be a sufficient penalty to a low-risk business with few employees, but as the risk of a business increases and more workers are employed, the fine becomes both smaller in severity and less of a deterrent.

A related concern of the Advisory Council is the magnitude of Trust Fund Claims. When an employee is injured at work, and it is discovered that the employer failed to provide coverage, the employee may obtain benefits through the DIA's Trust Fund. The Trust Fund was created in the statute as a protective measure to pay for the benefits of injured employees of uninsured employers. The Trust Fund is financed through assessments paid by the vast majority of employers who purchase insurance. In fiscal year 2004, approximately $4,331,754 was paid to uninsured claimants.

TRUST FUND PAYMENTS TO UNINSURED CLAIMANTS	
Fiscal Year 2004:	$4,331,754
Fiscal Year 2003:	$4,108,222
Fiscal Year 2002:	$4,579,380
Fiscal Year 2001:	$3,302,809
Fiscal Year 2000:	$3,390,180
Fiscal Year 1999:	$3,132,378

During the 2003-2004 Legislative Session, the Advisory Council recommended the passage of **Senate Bill 1705**, filed by Senator Steven A. Tolman, relative to the mandatory debarment or suspension of contractors who fail to carry workers' compensation insurance (along with other serious offenses) from participating in public contract bidding. The Advisory Council also supported the concept of **House Bill 2205**, filed by Representative Martin J. Walsh, which would have provided a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to pay workers' compensation premiums as mandated by Chapter 152. Additionally, the Advisory Council supported an outside section contained within the Governor's FY'05 Budget (House 1) that would have instituted inter-agency cooperation between the DIA and the Registry of Motor Vehicles to suspend or prohibit the issuance or renewal of a driver's license of an employer who is operating without insurance.

The Advisory Council will continue to support similar legislative initiatives during the 2005-2006 Legislative Session to ensure there are sufficient penalties for those companies who ignore the Workers' Compensation Insurance Mandate. The Advisory Council has formed a Legislative Subcommittee that will reexamine the appropriate fine-structure for the Stop Work Order system and will present recommendations to the Joint Committee on Commerce & Labor. The adoption of a stiffer fine structure will force fraudulent employers to purchase workers' compensation insurance while helping to alleviate multiple claims against the Trust Fund. The Advisory Council continues to support the DIA's efforts to strengthen the SWO process through internal changes.

Increased Funding for the Safety Grant Program

The Office of Safety is responsible for establishing and supervising programs that entail the education and training of employees and employers in the recognition, avoidance, and prevention of unsafe or unhealthy working conditions. To fulfill this mandate, the DIA awards grants to qualified applicants, based on a competitive selection process.

Since 1991, the Office of Safety has been providing grants under the "Occupational Safety and Health Education and Training Program." Historically, the Safety Grant Program has been funded with an annual budget of $800,000 and allots up to $30,000 in grants for each proposal. To date, the Office of Safety has funded a total of 557 preventive training programs, which have trained nearly 25,000 workers in Massachusetts. Clearly, this program has been a valuable success. By focusing on the pre-injury stages of workers' compensation, safety grants have potentially saved the Commonwealth's employers millions of dollars.

In September of 2004, the Advisory Council held their monthly meeting at the Frank Janas Training Center in Lawrence to examine ongoing safety initiatives in Massachusetts. At this meeting, the Council learned that on-the-job injury rates for young workers (under 18) in Massachusetts are nearly twice the rate of adults. Further troubling was the fact that nearly 25% of the workers who were killed in 2002 were immigrants (nearly double their representation in the Commonwealth's workforce).

The Advisory Council applauds the efforts made by the Office of Safety in providing education and training to employees on a variety of workplace safety issues. The Council is recommending that the DIA's Safety Grant Program receive $1,200,000 in funding in the fiscal year 2006 budget. Contained within this line-item, the Advisory Council recommends that "up to 25%" of the total funding be specifically earmarked for grants that address high-risk employees such as children, immigrants, and non-English speaking workers. The Advisory Council supports the Office of Safety's efforts in developing a tracking system that would measure the cost-savings to employers who utilize the safety grants. If cost-savings can be identified, it will help generate support within the Legislature for future funding efforts.

Adequate Funding for the Division of Occupational Safety

Since 1992, the Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform manner. In Massachusetts alone, surveys are collected from over 5,800 employers (200,000 nationwide) in an effort to represent the total private economy. Once data has been collected and correlated, these statistics are published in a report known as the *Annual Survey of Occupational Injuries and Illnesses* [see page 29, *Occupational Injuries and Illnesses*]. Funding for the annual survey is split 50/50 between state government (DOS) and the federal government (BLS).

The survey's data is calculated into incidence rates that measure the frequency of injuries. Specifically, the survey examines the frequency of non-fatal injuries and illnesses that occurred in the private sector workforce for every 100 full-time workers. Each year the level of incidence rates can be influenced by changes in the economic climate, working conditions, an employer's emphasis on safety and training, and the number of hours that employees work. In the past, both insurers and employers have found the data useful in assessing safety and injury trends. The Office of Safety has also expressed interest in utilizing the survey to identify high-risk industries that could be targeted for the DIA's Safety Grant Program.

On January 1, 2002, the Occupational Safety and Health Administration (OSHA) revised its requirement for recording occupational injuries and illnesses. The DOS is now required to collect data using the North American Industry Classification System (NAICS), rather than the Standard Industrial Classification System (SICS). This recent change to the classification system accentuates the importance that Massachusetts continue its participation in the program during these first benchmark years.

During the late stages of the FY'05 budget process, it became apparent that the DOS would not be receiving the necessary funding to continue its participation in the annual survey. In June of 2004, the Advisory Council formed a subcommittee to discuss possible funding alternatives to save this valuable program. Working with administrative members of the DIA and DOS, the subcommittee agreed that the survey greatly benefited both employers and the DIA's Safety Grant Program. In September of 2004, the DOS received $110,000 in a supplemental budget to cover the expenses associated with the survey and therefore would not need the assistance of the DIA.

Although the annual survey falls outside of the statutory mandate for DOS, the benefits of having comparable statewide injury data, which can be analyzed by industry, region, or injury type, far outweigh the cost of the program. The Advisory Council recommends that the Division of Occupational Safety receive adequate funding during the Fiscal Year 2006 budget process to allow the Commonwealth to continue its participation in the *Annual Survey of Occupational Injuries and Illnesses*. If adequate funding cannot be appropriated to the DOS line-item in Fiscal Year 2006, the Advisory Council recommends that the legislature appropriate additional funding to the Department of Industrial Accidents so that the administration of the survey can be conducted by the DIA's Office of Safety.

Examining the Necessity for a Second Injury Fund

Second injury funds were implemented throughout the United States following World War II as a financial incentive for employers to hire disabled veterans. In Massachusetts, Section 37 of the workers' compensation statute provides reimbursement to insurers for payments made in conjunction with a "second injury" claim. An employee is considered to suffer a second injury when an on-the-job accident or illness occurs that aggravates a pre-existing impairment. The occurrence of the preexisting impairment is immaterial as the impairment may be derived from any previous accident, disease, or congenital condition. The resulting disability, however, must be “substantially greater” due to the combined effects of the preexisting impairment and subsequent injury than the disability as a result of the subsequent injury alone. When the injury is determined to be a second injury claim, insurers become eligible to receive reimbursement from the DIA's Trust Fund of up to 75% of compensation paid after the first 104 weeks of payment.

In December of 2003, the manager of the Workers' Compensation Trust Fund appeared before the Advisory Council to address the policies and procedures of the DIA's Second Injury Fund. Council Members were surprised to learn of the growing volume of Section 37 cases since 1991 when the standard for eligibility became more strict. At the close of fiscal year 2004, 365 Section 37 claims were paid and settled, amounting to $19,739,158 in payments. Also troubling to the Advisory Council is the fact that a large portion of the Section 37 volume stems from a small group of attorneys who specialize in second injury cases.

At this time, there is no clear evidence whether the Commonwealth's employers and previously injured employees are benefiting from the Second Injury Fund. Since the early 1990's, as many as 16 states have abolished their second injury funds. Most recently, Georgia has passed legislation that will completely dissolve their second injury fund (known as the "Subsequent Injury Trust Fund") in 2008. This growing trend to eliminate second injury funds across the United States may reflect that the funds are not meeting their intended purposes.

In fiscal year 2005, the Advisory Council will formally address this issue by creating a subcommittee and working together with the DIA administration to determine the benefits and disadvantages of second injury funds. The subcommittee will also examine whether the Americans with Disabilities Act is already adequately protecting injured workers from employment discrimination, thereby making second injury funds obsolete. Finally, the Advisory Council will investigate whether employers are receiving adjustments to their experience modification factors as a result of these reimbursements.

Examining the Adequacy of IAB Medical Rates

The Division of Health Care Finance and Policy (DHCFP) regulates the rates of payment (fee schedule) for hospitals and health care providers rendering services covered by insurers under the Workers' Compensation Act. The fee schedule is subject to a regulatory proceeding ensuring a public process through which rate setting is established. Although rate negotiation is common, the rates that are set by the DHCFP are the only amount that an insurer is required to pay.

In October of 2004, the President of the Massachusetts Academy of Trial Attorneys (MATA) addressed the Advisory Council on the inadequacy of the current fee schedule. At this meeting, Council Members were informed that injured workers were being denied proper medical access because many rates contained in the fee schedule are much lower than the "usual and customary" rates of the medical providers and much lower than HMO and health insurance rates. The President of MATA warned Council Members that medical access could further be hampered if medical providers and insurers become unwilling to negotiate medical rates.

During the 2005-2006 Legislative Session, the Advisory Council will examine both legislative and regulatory initiatives regarding the adequacy of the fee schedule. The Advisory Council will also examine whether Administrative Judges should be empowered with the authority to determine a reasonable and fair rate in cases where disputed parties refuse to negotiate.

Removing Language Barriers in Workers' Compensation

During the past year, the DIA has taken initial steps in removing language barriers to non-English speaking workers who are navigating through the workers' compensation system. In the spring of 2004, the Office of Investigations developed a bilingual statewide public awareness campaign aimed at educating employers in the Commonwealth of the mandatory requirement to provide workers' compensation insurance. Both the posters and television advertisements were presented in Spanish in specific geographic regions. Recently, the DIA translated both the Employee and Employer Guides to Workers' Compensation into Spanish, Portuguese, Haitian-Creole, Chinese and Vietnamese.

The Advisory Council recommends that the DIA continue to take further measures in promoting accessibility to non-English speaking workers. In Massachusetts, more people speak Spanish than any other non-English language. At a minimum, the Advisory Council is recommending that the DIA translate the most commonly used public awareness posters into Spanish. The Advisory Council further suggests that the DIA work with community-based organizations to develop a bilingual videotape that will educate injured workers on the workers' compensation system. These videotapes should be made available for viewing to injured workers at each Regional Office. Finally, the DIA's website should have links to pre-approved non-profit community organizations that could provide assistance to both English and non-English speaking workers.

Automation of the Collection of Insurance Assessments

M.G.L. c.152, §65 states that revenues for the Special Fund and the Trust Fund shall be raised by an assessment on all employers. The Act specifies that the DIA must calculate an assessment rate which, when multiplied by an employer's standard premium, yields an employer's assessment amount. Insurance carriers are responsible for billing and collecting the proper assessments from insured employers. All assessment amounts must be separately stated on insurance bills and paid to the DIA on a quarterly basis, no later than one month after the end of the quarter. The DIA is responsible for billing self insured employers and self insurance groups directly for their share of assessments.

The Advisory Council first voiced concern about the DIA's inability to verify payment of assessments collected by insurance carriers in the FY'97 Annual Report. In response to this concern, the DIA selected three accounting firms to review the assessment process to ensure adequate payments have been collected and remitted by the insurance carriers. Through the end of fiscal year 2004, reviews were completed for approximately 41 insurance companies, while approximately 17 additional companies were in the process of being reviewed. The DIA has welcomed the opportunity to work with the insurance carriers to resolve any discrepancies that have been noted as a result of the reviews and remains committed to resolving all outstanding issues through whatever means necessary.

The Advisory Council strongly supports the continued efforts of the DIA in using independent auditors to verify that insurance companies are collecting and submitting proper assessment amounts from employers. The Advisory Council also supports the DIA's decision to hire an accountant to work full-time with the auditing firms and to ultimately develop an assessment payment process that is fully automated with the insurance carriers. The Advisory Council has suggested that the DIA research how other states secure their revenues so that an efficient and accurate system can be implemented in Massachusetts. Thus far, the assessment audit has been a success with the DIA receiving over $3 million in remittances as a result of the reviews. The Advisory Council believes that this entire process will be beneficial to both insurers and the employers who fund the system by ensuring that proper credit and debit adjustments are applied to the respective parties.

Endorsement of Scar Based Disfigurement Legislation

During the 2003-2004 Legislative Session, the Advisory Council recommended the passage of **House Bill 2382**, filed by Representative Antonio Cabral, which would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. In 2000, the Advisory Council asked the actuarial firm Tillinghast - Towers Perrin to estimate the impact on workers' compensation costs if scarring awards were restored to their pre-Chapter 398 levels. Although Tillinghast was unable to quantify the impact of such a proposed revision due to incomplete data, it was suggested that such a change would have a "relatively minimal impact on system costs."

Although past legislative efforts have been unsuccessful, the Advisory Council will continue to support similar legislation in the 2005-2006 Legislative Session to rightfully compensate workers for all disfigurement, whether or not scar-based, regardless of its location on the body, subject to a $15,000 maximum benefit.

LEGISLATION

During the 2003-2004 Legislative Session, approximately forty-three bills were filed by the House and Senate seeking to amend the workers' compensation system (see Appendix O for a complete list of legislation). The vast majority of bills concerning workers' compensation matters are referred to the Joint Committee on Commerce & Labor. Once legislation is referred to this committee, a public hearing is held on the bills. For a list of members of the Joint Committee on Commerce & Labor, see Appendix C.

Commerce & Labor Hearing

On July 24, 2003, the Joint Committee on Commerce & Labor held a hearing on all workers' compensation legislation before the committee. Representatives from the Advisory Council appeared before the committee to testify on four bills that had been previously endorsed by the Advisory Council.

At the Commerce & Labor hearing, the Council expressed support for **House Bill 2924**, filed by Representative Koczera, which would "naturally" stagger judicial terms at the DIA by making the initial appointment of all Administrative Judges for 6-year terms.

The Council also supported (with a stipulation that it be amended) **House Bill 2380**, filed by Representative Cabral, which would subject the Senior Judge, the Administrative Judges, and the Administrative Law Judges to a judicial code of conduct. The Advisory Council offered an amendment to this legislation that would substitute the American Bar Association's Model Code of Judicial Conduct for State Administrative Law Judges, in lieu of the current language as set forth by the Supreme Judicial Court.

The Council also expressed support for **House Bill 2382**, filed by Representative Cabral, which would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable.

Finally, the Advisory Council endorsed the concept of **House Bill 2205**, filed by Representative Walsh. This bill would provide a vehicle for both private citizens and insurers to bring forth a civil action against employers who illegally fail to pay workers' compensation premiums as mandated by Chapter 152.

See Appendix H for the Advisory Council's written testimony at this hearing.

Legislation Endorsed by the Advisory Council

Of the forty-three bills filed in the 2003-2004 Legislative Session, six bills were endorsed by the Advisory Council (five bills before the Joint Committee on Commerce & Labor and one bill before the Joint Committee on State Administration). The affirmative vote of at least seven voting members must occur in order for a bill to be endorsed by the Advisory Council.

SENATE BILL 1705
Filed By: Sen. Steven A. Tolman
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Debarment or Suspension of Contractors (c.29, §29F)

Senate Bill 1705 would amend M.G.L. c.29, §29F, which allows the Commonwealth the optional power of debarring or suspending contractors and subcontractors from engaging in any of the Commonwealth's public sector projects for not carrying workers' compensation insurance or other serious offenses.[1] This proposed legislation would amend Section 29F by replacing the word "may" to "shall," effectively making the debarment or suspension of violators mandatory. This bill was filed by Senator Steven A. Tolman and the Massachusetts Building Trades Council in an effort to level the playing field for contractors who are at a competitive disadvantage when bidding on public sector projects because they complied with the law by securing workers' compensation insurance when their competitors did not.

HOUSE BILL 2205
Filed By: Rep. Martin J. Walsh
Type of Bill: NEW
Endorsed by Advisory Council: YES (in concept)
Laws Affected: Private Right of Action to Recover WC Coverage Payments (c.152, §25C)

This new bill would allow up to 10 people to bring a civil action against an employer to recover amounts which should have been paid in securing proper workers' compensation insurance as mandated by Chapter 152. Such a person seeking civil action could petition either the Attorney General's Office, the Commissioner of Insurance, or a superior court to hold a "probable cause hearing." At the hearing, it shall be *prima facie* evidence that such probable cause exists if it is shown that:

- an employee was paid any portion of wages in cash with no deductions or taxes withheld;
- no accompanying pay slip showing the wage payment and deductions as required by law;
- an individual was misclassified as an independent contractor when actually an employee;
- wages were not timely paid;
- the employer failed to withhold from the employee's wages all related state taxes; or
- employees have not been properly reported on certified payroll records as required by law.

If the decision shows that probable cause exists, the person who brought the petition shall serve a copy of the decision to any insurer that was entitled to collect amounts not paid and the persons shall simultaneously state any intention to file suit under this Section. Any persons who prevail in an action shall be entitled to recover 25% of the amounts unlawfully not paid or $25,000, whichever is less.

[1] Current law allows state regulators the option to debar contractors for the following serious offenses: conviction for bribery, theft, forgery, destroying business records, receiving stolen property or rigging bids. Debarment may also be issued if a contractor is found to have violated any of the following statutes: anti-trust, campaign contribution, employment discrimination, hours of labor, prevailing wages, overtime pay, equal pay, child labor or workers' compensation.

HOUSE BILL 2380
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: YES (with ABA language amended)
Laws Affected: Code of Judicial Conduct - Senior Judge, AJ's, and ALJ's (c.23F, §8)

This refiled bill (previously H.2648) would require the Senior Judge, the Administrative Judges and Administrative Law Judge's to be subject to the Code of Judicial Conduct as promulgated by the Supreme Judicial Court. A previous version of this bill was endorsed by the Advisory Council in the Fiscal Year 2002 Annual Report.

HOUSE BILL 2382
Filed By: Rep. Antonio Cabral
Type of Bill: Refile
Endorsed by Advisory Council: YES
Laws Affected: Benefits for Specific Injuries (c.152, §36(k)) - Scar-Based Disfigurement

This refiled bill (previously H.2649) would eliminate the requirement that scar-based disfigurement appear on the face, neck or hands to be compensable. This would require compensation for all disfigurement, whether or not scar-based, regardless of its location on the body. Section 36(k) was amended by Chapter 398 to limit payments for purely scar-based disfigurement by requiring benefits only when the disfigurement is on the face, neck, or hands.

NOTE: In July of 2002, the Advisory Council sent a letter to Representative Greene and Senator Pacheco stating that the "Council continues to be receptive to amending Section 36(k) to allow compensation for scar-based disfigurement regardless of its location on the body." However, in reference to Senate Bill 2358, the Council noted that they could not reach a consensus on a SAWW multiplier to determine a maximum benefit "until a thorough cost-analysis can be conducted." House Bill 2382 would not affect the $15,000 maximum benefit for scar-based disfigurement currently in the statute.

HOUSE BILL 2924
Filed By: Rep. Robert M. Koczera
Type of Bill: NEW
Endorsed by Advisory Council: YES
Laws Affected: Judicial Appointments - Judicial Performance Review (c.23E, §4)

Section 1 of this new bill, endorsed by the Advisory Council, would attempt to stagger judicial terms "naturally" by clarifying that newly appointed Administrative Judges (AJ's) be appointed to new six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. In theory, the current law could create a situation in which a newly appointed Judge would only be appointed to serve a 1-year term, if the slot they were filling was vacated after 5-years.

Section 2 of this proposed legislation would require the Senior Judge to review the performance of newly appointed Administrative Judges after their first 2-years of service. If the performance review supports the continuation of their term, the AJ may continue to serve the remainder of their term. However, if the performance review recommends against a continuation of their term, the performance review would be submitted to the Governor for appropriate action.

Legislation Enacted

Of the forty-three bills filed in the 2003-2004 Legislative Session, only one bill was enacted into law regarding workers' compensation matters. On August 25, 2004, Acting Governor Kerry Healey signed into law **House Bill 4465** regarding the judicial appointments of Industrial Accident Board (IAB) members at the DIA. This bill, filed by Representative Michael J. Rodrigues and endorsed by the Advisory Council, is a redraft of House Bill 2380 (Cabral) and House Bill 2924 (Koczera).

The enactment of House Bill 4465 will stagger judicial terms "naturally" by clarifying that newly appointed Administrative Judges (AJs) and Administrative Law Judges (ALJs) be appointed to new six-year terms, rather than the current practice of being appointed to fill the remaining time-period of a vacant term. The Senior Judge is required to review the performance of newly appointed AJs and ALJs after their first 2-years of service. Finally, this new law requires the Senior Judge, the Administrative Judges and Administrative Law Judges to be subject to the "Model Code of Judicial Conduct for State Administrative Law Judges," as promulgated by the American Bar Association.

The importance of this legislation being passed into law was recently validated when the terms of eight Administrative Judges and all six Administrative Law Judges expired during May and June of 2004. This resulting congestion within the judicial appointment process would have likely occurred every six years if no corrective measures had been implemented. Furthermore, with the expected arrival of multiple judges who have never served on the IAB, this new law will help preserve the quality of the judicial roster by requiring the Senior Judge to review judicial performance after two years of service. The Advisory Council strongly believes that the poor performance of even one IAB member can have an adverse effect on all participants in the workers' compensation system.

SECTION
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OVERVIEW

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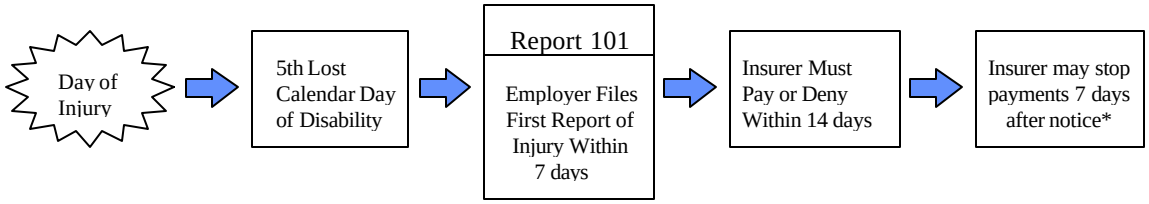
PROVISIONS TO RESOLVE DISPUTES

Figure 1: Schedule of Events

Schedule of Events:



*The insurer may stop payments unilaterally (with seven days notice) only if the case remains within the 180 day "pay without prejudice period," and the insurer has not been assigned or accepted liability for the case. Otherwise, the insurer must file a "complaint" and go through the dispute resolution process.

Workers' Compensation Claims

When an employee is disabled or incapable of earning full wages for five or more calendar days, or dies, as the result of a work-related injury or disease, the employer must file a First Report of Injury. This form must be sent to the Office of Claims Administration at the DIA, the insurer, and the employee within seven days of notice of the injury. If the employer does not file the required First Report of Injury with the DIA, they may be subject to a fine.

The insurer then has 14 days upon receipt of the employer's First Report of Injury, to either pay the claim or to notify the DIA, the employer, and the employee of their refusal to pay.[2] When the insurer pays a claim, they may do so without accepting liability for a period of 180 days. This is known as the "pay without prejudice period." This period establishes a window where the insurer may refuse a claim and stop payments at will. Up to 180 days, the insurer can unilaterally terminate or modify any claim, as long as it specifies the grounds and factual basis for so doing. [3] The purpose of the pay without prejudice period is to encourage the insurer to begin payments to the employee instead of outright denying the claim.

After a conference order is issued or the pay without prejudice period expires, the insurer may not stop payment without an order from an Administrative Judge (AJ). The insurer must request a modification or termination of benefits, based on an impartial medical exam and other statutory requirements. A discontinuance or modification of benefits may take place no sooner than 60 days following a referral to the division of dispute resolution.

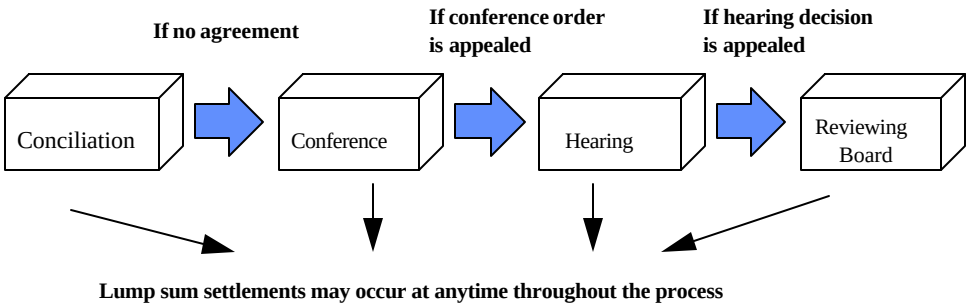
[2] If there is no notification or payment has not begun, the insurer is subject to a fine of $200 after 14 days, $2,000 after 60 days, and $10,000 after 90 days.

[3] The pay without prejudice period may be extended up to one year under special circumstances. The DIA must be notified seven days in advance.

Dispute Resolution Process

Requests for adjudication may be filed either by an employee seeking benefits or an insurer seeking modification or discontinuance of benefits following the payment without prejudice period.

Figure 2: Dispute Resolution Process



Dispute resolution begins at conciliation, where a conciliator will attempt to resolve a dispute by informal means. Disputes should go to conciliation within 15 days of receipt of the case from the division of administration.

A dispute not resolved at conciliation will then be referred to a conference, where it is assigned to an AJ who retains the case throughout the process if possible. The insurer must pay an appeal fee of 65% of the state average weekly wage (SAWW) or 130% of the SAWW if the insurer fails to appear at conciliation. The purpose of the conference is to compile the evidence and to identify the issues in dispute. The AJ may require both injury and hospital records. A conference order may be appealed to a hearing within 14 days from the filing date of such order.

At the hearing, the AJ reviews the dispute according to oral and written documentation. The procedure at a hearing is formal and a verbatim transcript of the legal proceeding is recorded by a stenographer. Witnesses are examined and cross-examined according to the Massachusetts Rules of Evidence. The AJ may grant a continuance for reasons beyond the control of any party. Either party may appeal a hearing decision within 30 days.

This time limit for appeals may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then proceed to the reviewing board, where a panel of ALJ's will hear the case.

At the reviewing board, a panel of three ALJ's review the evidence presented at the hearing. The ALJ's may request oral arguments from both sides. They can reverse the AJ's decision only if they determine that the decision was beyond the scope of authority, arbitrary, capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact.

All orders from the dispute resolution process may be enforced by the Superior Court of the Commonwealth. Reviewing Board cases may also be appealed to the Appeals Court. The cost of appeals are reimbursed to the claimant (in addition to the award of the judgment), if the claimant prevails.

Lump Sum Settlements

A case can be resolved at any point during the DIA's three-step dispute resolution process by either settlement or by the decision of an Administrative Judge (AJ) or dministrative law judge (ALJ).

Conciliators may "review and approve as complete" lump sum settlements, a standard that allows the conciliator to review a completed lump sum settlement. Conciliators or the parties at conciliation may also refer a case to a lump sum conference, where an ALJ will decide if a lump sum settlement is in the best interest of the parties.

AJ's, at the conference or hearing level of dispute resolution, may approve lump sum settlements in the same manner that an ALJ approves a settlement at the lump sum conference. AJ's and ALJ's must determine whether settlements are in the best interest of the employee, and they may reject a settlement offer if it appears to be inadequate. Dispute resolution begins at conciliation, where a conciliator will attempt to resolve a dispute by informal means.

Alternative Dispute Resolution Measures

Arbitration & Mediation - At any time prior to five days before a conference, a case may be referred to an independent arbitrator. The arbitrator must make a decision whether to vacate or modify the compensation pursuant to M.G.L. c.251, §12 and §13. The parties involved may agree to bring the matter before an independent mediator at any stage of the proceeding. Mediation shall in no way disrupt the dispute resolution process, and any party may continue with the process at the DIA if they decide to do so.

Collective Bargaining - An employer and a recognized representative of its employees may engage in collective bargaining to establish certain binding obligations and procedures related to workers' compensation. Agreements are limited to the following topics: supplemental benefits under §34, §34A, §35, and §36; alternative dispute resolution (arbitration, mediation, conciliation); limited list of medical providers; limited list of impartial physicians; modified light duty return to work program; adoption of a 24-hour coverage plan; establishing safety committees and safety procedures; and establishing vocational rehabilitation or retraining programs.

SUMMARY OF BENEFITS

An employee who is injured during the course of employment or suffers from work-related mental or emotional disabilities, as well as occupational diseases, is eligible for workers' compensation benefits. These benefits include weekly compensation for lost income during the period the employee cannot work.

Indemnity payments vary, depending on the average weekly wage of the employee (AWW) and the degree of incapacitation. The statute dictates that the maximum benefit be set at 100% of the State Average Weekly Wage (SAWW) and that a minimum benefit of at least 20% of the SAWW.[4] In addition, the insurer is required to furnish medical and hospital services, as well as any medicines if needed. The insurer must also pay for vocational rehabilitation services if the employee is determined to be suitable by the DIA.

Below is a list of the SAWW's, since 1992, and the maximum (SAWW) and minimum benefit levels for §34 and §34A claims. In October of 2004, the SAWW experienced a $34.32 increase from the previous year.

Table 1: Indemnity Benefits

Effective Date	Maximum Benefit	Minimum Benefit
10/1/92	$543.30	$108.66
10/1/93	$565.94	$113.19
10/1/94	$585.95	$117.19
10/1/95	$604.03	$120.81
10/1/96	$631.03	$126.21
10/1/97	$665.55	$131.11
10/1/98	$699.91	$131.98
10/1/99	$749.69	$149.93
10/1/00	$830.89	$166.18
10/1/01	$890.94	$178.19
10/1/02	$882.57	$176.51
10/1/03	$884.46	$176.89
10/1/04	**$918.78**	**$183.76**

Source: DIA Circular Letter No. 310 - Table III (October 1, 2004)

[4] The Statewide Average Weekly Wage (SAWW) is determined under M.G.L. c.151A, §29(2) & promulgated by the Director the Division of Employment and Training. As of October 1, 2004, the SAWW is $918.78.

Indemnity and Supplemental Benefits

The following are the various forms of indemnity and supplemental benefits employees may receive depending on their average weekly wage, state average weekly wage, and their degree of disability.

Temporary Total Disability (§34) - Compensation will be 60% of the employee's average weekly wage (AWW) before injury, while remaining above the minimum and below the maximum payments that are set for each form of compensation. The maximum weekly compensation rate is 100% of the state average weekly wage (**$918.78**), while the minimum is 20% of the SAWW (**$183.76**), if claims involve injuries occurring on or after October 1, 2004. The limit for temporary benefits is 156 weeks.

Partial Disability (§35) - Compensation is 60% of the difference between the employee's AWW before the injury and the weekly wage earning capacity after the injury. This amount cannot exceed 75% of temporary benefits under §34 if they were to receive those benefits. The maximum benefit period is 260 weeks for partial disability, but may be extended to 520 weeks.

Permanent and Total Incapacity (§34A) - Payments will equal 2/3 of the AWW following the exhaustion of temporary (§34) and partial (§35) payments. The maximum weekly compensation rate is 100% of the state average weekly wage (**$918.78**), while the minimum is 20% of the SAWW (**$183.76**), if claims involve injuries that occurred on or after October 1, 2004. The payments must be adjusted each year for cost of living allowances (COLA benefits).

Death Benefits for Dependents (§31) - The widow or widower that remains unmarried shall receive 2/3 of the worker's AWW, but not more than the state's AWW or less than $110 per week. They shall also receive $6 per week for each child (not to exceed $150 in additional compensation). There are also benefits for other dependents. Benefits paid to all dependents cannot exceed 250 times the state AWW plus any cost of living increases (COLA). However, children under 18 years old may continue to receive payments even if the maximum has been reached. Burial expenses may not exceed $4,000.

Subsequent Injury (§35B) - An employee who has been receiving compensation, has returned to work for two months or more and is subsequently re-injured, will receive compensation at the rate in effect at the time of the new injury (unless the old injury was paid in a lump sum). If the old injury was settled with a lump sum, then the employee will be compensated only if the new claim can be determined to be a new injury.

Attorney's Fees

The dollar amounts specified for attorney's fees are listed in M.G.L. c.152, §13A(10). As of October 1, 2004, subsections 1 through 6 were updated to reflect adjustments to the State Average Weekly Wage. Below is a summary of the attorney's fee schedule:

(1) When an insurer refuses to pay compensation within 21 days of an initial liability claim but prior to a conference agrees to pay the claim (with or without prejudice), the insurer must pay an attorney's fee of **$918.55** plus necessary expenses. If the employee's attorney fails to appear at a scheduled conciliation, the amount paid is **$459.27**.

(2) When an insurer contests a liability claim and is ordered to pay by an Administrative Judge at conference, the insurer must pay the employee's attorney a fee of **$1,312.21**. The Administrative Judge can increase or decrease this fee based on the complexity of a case and the amount of work an attorney puts in. If the employee's attorney fails to appear at a scheduled conciliation, the fee may be reduced to **$656.10**.

(3) When an insurer contests a claim for benefits other than the initial liability claim (as in subsection 1) and fails to pay compensation within 21 days, yet agrees to pay the compensation due, prior to conference, the insurer must pay the employee's attorney fee in the amount of **$656.10** plus necessary expenses. This fee can be reduced to **$328.06** if the employee's attorney fails to appear at a scheduled conciliation.

(4) When an insurer contests a claim for benefits or files a complaint to reduce or discontinue benefits by refusing to pay compensation within 21 days, and the order of the Administrative Judge after a conference reflects the written offer submitted by the claimant (or conciliator on the claimant's behalf), the insurer must pay the employee's attorney a fee of **$918.55** plus necessary expenses. If the order reflects the written offer of the insurer, no attorney fee should be paid. If the order reflects an amount different from both submissions, the fee should be in the amount of **$459.27** plus necessary expenses. Any fee should be reduced in half if the employee's attorney fails to show up to a scheduled conciliation.

(5) When the insurer files a complaint or contests a claim and then, either a) accepts the employee's claim or withdraws its own complaint within 5 days of a hearing, or b) the employee prevails at a hearing, the insurer shall pay a fee to the employee's attorney in the amount of **$4,592.74** plus necessary expenses. An Administrative Judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

(6) When the insurer appeals the decision of an Administrative Judge and the employee prevails in the decision of the Reviewing Board, the insurer must pay a fee to the employee's attorney in the amount of **$1,312.21**. An Administrative Judge may increase or decrease this amount based on the complexity of the case and the amount of work an attorney puts in.

SECTION
- 2 -

WORKPLACE INJURY & CLAIM STATISTICS

Occupational Injuries and Illnesses.....**29**

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OCCUPATIONAL INJURIES AND ILLNESSES

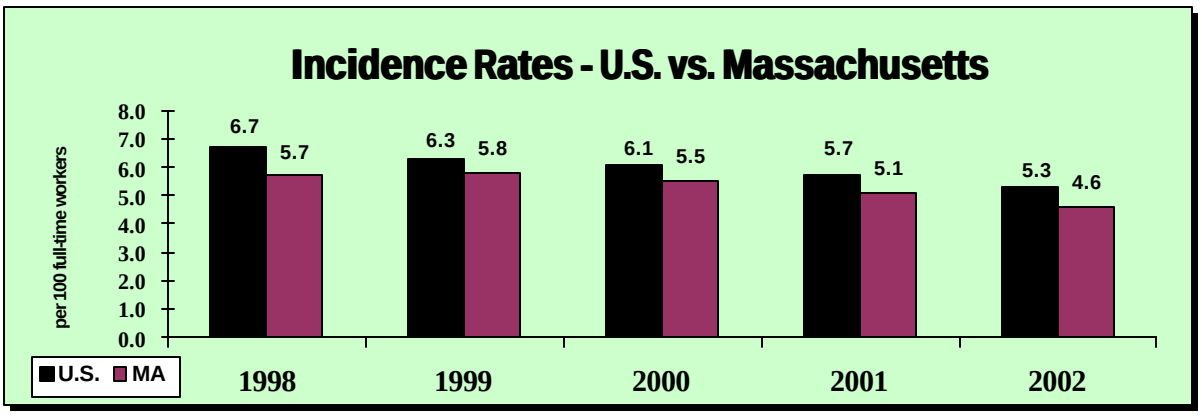
Since 1992, the Division of Occupational Safety (DOS) has been in a partnership with the U.S. Department of Labor, Bureau of Labor Statistics (BLS), in an effort to collect injury and illness data in a uniform format. Throughout the country, surveys are collected from over 182,800 private employers in an effort to represent the total private economy. Once data has been collected and correlated, these statistics are published in a document known as the *Annual Survey of Occupational Injuries and Illnesses*. Funding for the annual survey is split 50/50 between state government (DOS) and the federal government (BLS).

On January 1, 2002, the Occupational Safety and Health Administration (OSHA) revised its requirement for recording occupational injuries and illnesses. The DOS will now collect data using the North American Industry Classification System (NAICS), rather than the Standard Industrial Classification System (SICS). Due to the revised requirements, the estimates from the 2002 survey are not comparable with those from prior years.

Injury and Illness Incidence Rates

Incidence rates are calculated to measure the frequency of injuries. Specifically, the study examines the frequency of non-fatal injuries and illnesses that occurred in the private sector workforce (not including the self-employed, farms with less than 11 employees, private households, and employees in Federal, State and local government) for every 100 full-time workers. Each year the level of incidence rates can be influenced by changes in the economic climate, working conditions, an employer's emphasis on safety, and the number of hours that employees work. In 2002, Massachusetts had a population of 6,427,801 people with a workforce of 3,202,327 workers.

During 2002, the private sector workforce in the United States experienced 4.7 million non-fatal injuries and illnesses, resulting in an incidence rate of 5.3 cases per 100 full-time workers. In Massachusetts alone, there were 108,900 occupational injuries and illnesses, resulting in an incidence rate of 4.6. The chart below exhibits how occupational and injury illness rates have steadily declined in Massachusetts from 1998 to 2002. The chart also displays how incidence rates in Massachusetts have consistently remained lower than the National rates.



Incidence Rates by Region

The following table exhibits a regional breakout of the injury and illness incident rates per 100 full-time workers since 1997. The table demonstrates the downward trend in incidence rates both nationally and within Massachusetts. In 2002, Massachusetts had an incident rate of 4.6 work-related injuries or illnesses (resulting in lost work-time) for every 100 full-time workers in private industry. For the eleventh consecutive year, Massachusetts ranks the lowest for incidence rates among all New England states and is well below the national average of 5.3.

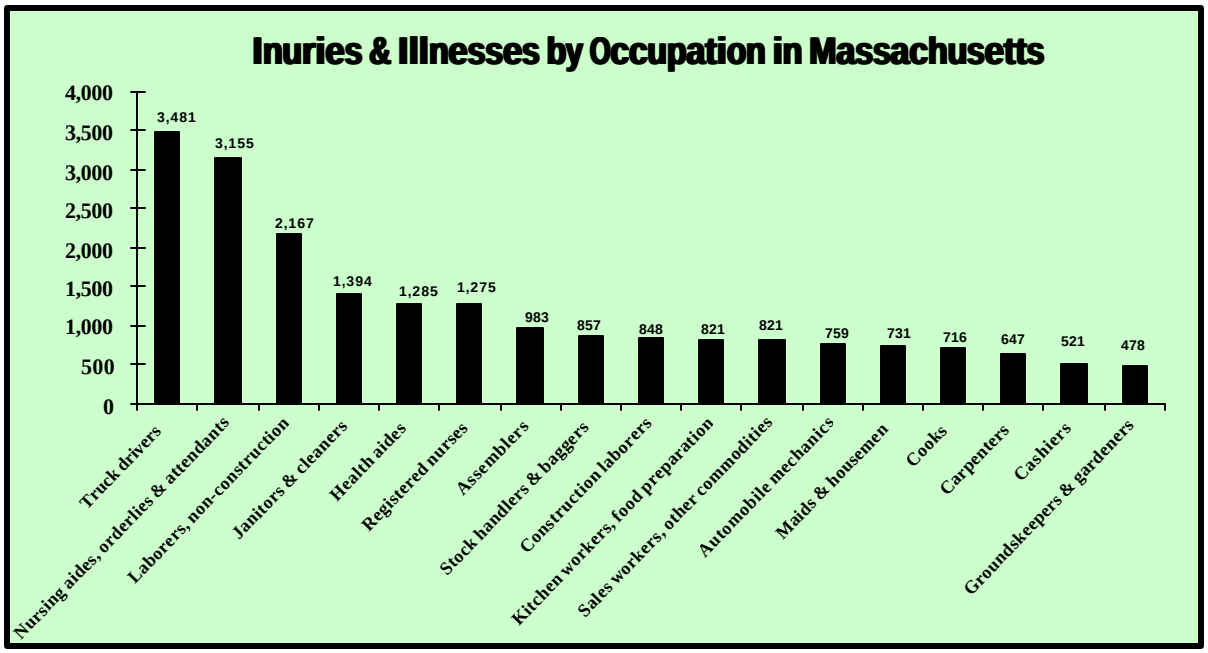
Table 2: Injury and Illness Incidence Rates - U.S. and New England 1997-2002 (Private Industry)

Region	2002	2001	2000	1999	1998	1997
United States……	5.3	5.7	6.1	6.3	6.7	7.1
Massachusetts…..	4.6	5.1	5.5	5.8	5.7	5.7
Connecticut……..	5.4	6.3	6.7	6.8	7.1	6.6
Maine……...	8.1	8.7	9.0	9.3	9.2	8.7
Rhode Island……	5.3	6.8	no data	7.0	6.7	7.8
Vermont……...	6.7	7.0	6.9	7.6	6.9	6.7
New Hampshire...	no data	no data	no data	no data	no data	no data

Source: Bureau of Labor Statistics - Boston Office.

Injuries & Illnesses by Occupation

The survey also has the ability to categorize the number of injuries and illnesses by occupation in Massachusetts. In 2002, truck drivers and nursing aides, orderlies and attendants had the highest number of injuries and illnesses involving days away from work in Massachusetts.



Source: Bureau of Labor Statistics - Boston Office.

Incidence Rates by Industry

The survey also has the ability to categorize incidence rates by industry. In Massachusetts, the agriculture, forestry, and fishing industry had the highest overall incidence rate in 2002, with 7.8 injuries for every 100 full-time workers. Finance, insurance and real estate had the lowest incidence rates, with 1.1 injuries per 100 workers.

Table 3: Nonfatal Injury & Illness Incidence Rates by Industry - Massachusetts 1997-2002

MASSACHUSETTS (Industry Division)	**2002**	**2001**	**2000**	**1999**	**1998**	**1997**
Private Industry:	**4.6**	**5.1**	**5.5**	**5.8**	**5.7**	**5.7**
Agriculture, forestry, and fishing:	7.8	8.1	7.7	11.6	10.8	10.7
Construction:	6.8	9.0	9.4	9.5	9.0	10.3
Manufacturing:	5.3	5.4	6.0	6.3	6.6	7.1
▪ Durable goods:	5.1	4.7	5.7	5.7	6.0	N/A
▪ Non-durable goods:	5.6	6.8	6.5	7.2	7.5	N/A
Transportation & public utilities:	7.4	8.2	8.2	8.1	9.3	8.9
Wholesale and retail trade:	5.6	5.6	6.9	6.6	5.9	5.6
▪ Wholesale trade:	5.5	5.4	7.6	6.1	6.2	N/A
▪ Retail trade:	5.3	5.7	6.6	6.8	5.8	N/A
Finance, insurance, real estate:	1.1	1.4	1.4	1.7	1.9	2.2
Services:	3.9	4.4	4.5	5.0	4.9	5.6

Source: Bureau of Labor Statistics - Boston Office.

Fatal Work Injuries

Fatal work injuries are calculated nationally each year by the U.S. Department of Labor, Bureau of Labor Statistics. The program, known as the *Census of Fatal Occupational Injuries*, tracks data from various states and federal administrative sources including death certificates, workers' compensation reports and claims, reports to various regulatory agencies, and medical examiner reports. Much like the *Annual Survey of Occupational Injuries and Illnesses*, this census is a federal/state cooperative venture in which costs are split equally. The collection of data in 2003 marks the 12th year that all 50 states (and the District of Columbia) have participated in this survey.

In 2003, a total of 5,559 work-related fatalities were recorded nationally by the program, representing a small increase from the revised total of 5,534 fatalities in 2002. Although the number of workplace fatalities increased minimally on the national level, Massachusetts experienced a significant increase in fatalities (67%) from the previous year (77 fatalities in 2003 / 46 fatalities in 2002).

In 2003, the leading cause of workplace death in Massachusetts came from transportation incidents in which 27 workers were killed. Nationally, transportation incidents were also the leading cause of on-the-job fatalities, accounting for 42% of the fatal work injuries in 2003. Following transportation incidents in Massachusetts, workers were killed by falls (24), contact with objects and equipment (12), assaults and violent acts (8), and fires and explosions (3).

The following chart details the number of fatalities by state and event in the Northeast Region.

Figure 3: Fatal Occupational Injuries by State and Event or Exposure, 2003 (Northeast Region)

State of Injury	Total Fatalities		Event or Exposure (state total for 2003)					
	2002	2003	Transportation Incidents	Assaults & Violent Acts	Contact with Objects & Equipment	Falls	Exposure to Harmful Substances	Fires & Explosions
U.S. Total……..	5,524	5,559	2,357	901	911	691	485	198
Northeast……..	710	726	269	136	111	120	48	37
Massachusetts….	46	77	27	8	12	24	--	3
Connecticut…….	39	36	17	9	4	4	--	--
Maine……..	30	23	9	--	7	3	4	--
New Hampshire..	19	19	7	3	4	3	--	--
New Jersey…….	129	104	41	16	18	19	7	3
New York……..	238	227	77	66	25	35	15	9
Pennsylvania…...	188	208	82	34	34	32	22	4
Rhode Island…...	8	18	--	--	3	--	--	18
Vermont……..	11	14	9	--	4	--	--	--

Source: Bureau of Labor Statistics, News - USDL-04-1830

CASE CHARACTERISTICS

The following tables and statistics illustrate trends, by "injury kind" in claims, average claim cost, and frequency for the five most recent years of available data. [5] This data is derived from insurance claims paid by commercial insurers writing policies in Massachusetts and does not include data from self-insured employers or self-insurance groups (SIGs). Insurance data is not considered reliable until several years after the policy year in which the claims occurred. For this reason, the most recent year comprising of reliable data is the 2001/2002 policy year. Each year of the data is developed to the fifth report, so the years can be compared equally.

Case Data By Injury Type

Table 4: Developed Claim Counts (Including Large Deductibles)

Composite Policy Year	*Injury Kind 1 Fatal*	*Injury Kind 2 Permanent Total*	*Injury Kinds 3&4 Partial Disability*	*Injury Kind 5 Temporary Total*	*Injury Kind 6 Medical Only*
1997/1998	43	58	6,683	24,212	77,114
1998/1999	33	59	6,823	23,699	76,417
1999/2000	24	53	6,631	25,043	77,818
2000/2001	36	48	5,647	24,048	74,224
2001/2002	38	69	5,379	22,229	70,025

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 2-3.

Table 5: Average Claim Costs - "Indemnity + Medical" (Including Large Deductibles)

Composite Policy Year	*Injury Kind 1 Fatal*	*Injury Kind 2 Permanent Total*	*Injury Kinds 3&4 Partial Disability*	*Injury Kind 5 Temporary Total*	*Injury Kind 6 Medical Only*
1997/1998	262,690	686,371	53,348	8,286	395.45
1998/1999	282,181	917,197	54,681	9,511	414.94
1999/2000	385,984	778,022	60,524	11,417	443.39
2000/2001	345,651	343,470	66,320	13,555	473.08
2001/2002	362,597	650,521	75,647	13,316	505.60

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

[5] It is important to note that the WCRIBM claim categories ("injury kind") do not correspond to specific sections of the Workers' Compensation Act. For example, the permanent total category includes predominantly section 34A benefits, but may also include benefits under section 30 and section 36.

Table 6: Average Claim Costs - Indemnity (Including Large Deductibles)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total
1997/1998	257,388	423,015	39,434	5,378
1998/1999	251,771	423,933	40,094	6,152
1999/2000	376,315	432,776	43,057	7,575
2000/2001	341,197	228,347	49,343	9,291
2001/2002	353,360	381,847	55,516	8,750

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

Table 7: Average Claim Costs - Medical (Including Large Deductibles)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total	Injury Kind 6 Medical Only
1997/1998	5,302	263,356	13,913	2,908	395
1998/1999	30,410	493,264	14,586	3,359	415
1999/2000	9,668	345,246	17,467	3,842	443
2000/2001	4,454	115,124	16,977	4,264	473
2001/2002	9,237	268,674	20,131	4,566	506

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-3.

Claim Frequency

Based on Developed Payroll and Developed Claim Counts
Unadjusted for Class Mix Changes

Table 8: Claim Frequency (Number of Claims per Million Worker-Weeks)

Composite Policy Year	Injury Kind 1 Fatal	Injury Kind 2 Permanent Total	Injury Kinds 3&4 Partial Disability	Injury Kind 5 Temporary Total	Injury Kind 6 Medical Only
1997/1998	0.484	0.653	75.22	272.52	867.96
1998/1999	0.365	0.658	76.03	264.11	851.59
1999/2000	0.246	0.555	69.22	261.44	812.42
2000/2001	0.358	0.470	55.42	236.02	728.46
2001/2002	0.373	0.680	52.81	218.23	687.45

Source: WCRIBM, schedule Z data by injury type (developed to 5th report) from Section V-D Exhibit 1-4.

SECTION
- 3 -
DISPUTE RESOLUTION

Cases Filed at the DIA.....**37**

Conciliation.....**38**

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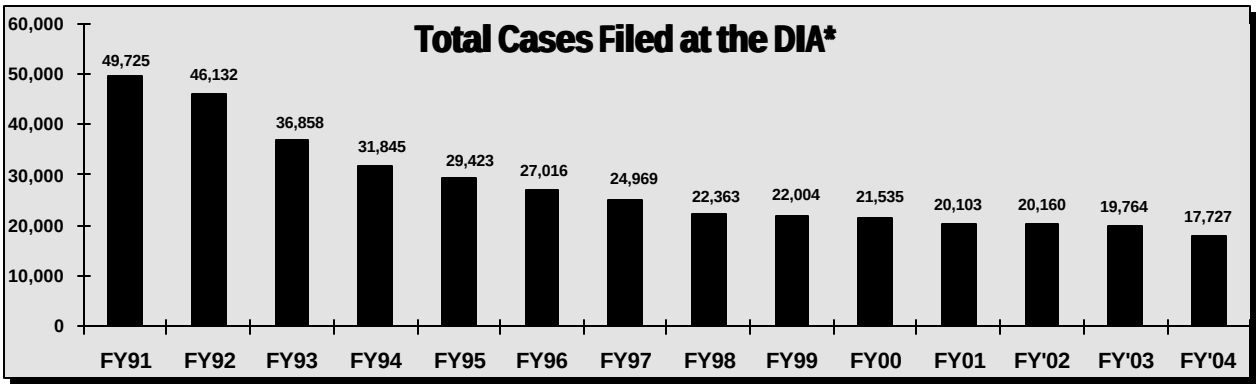
CASES FILED AT THE DIA

Cases originate at the DIA when any of the following are filed: *an employee's claim for benefits, an insurer's complaint for termination or modification of benefits, a third party claim, a request for approval of a lump sum settlement, or a Section 37/37A request*. As demonstrated in Figure 4, there has been a significant decline (-64%) in the DIA caseload since the implementation of the 1991 Reform Act. In fiscal year 2004, the total number of cases filed at the DIA decreased by 10% from the previous fiscal year.

Figure 4: Total Cases Filed at the DIA, FY'91 - FY'04



Source: CMS Report 28

Employee claims, which account for 72% of the total cases filed at the DIA, decreased significantly by 1,730 cases in FY'04. In 1991, employee claims reached an all time high of 23,240 cases filed. Employee claims have decreased by 45% since 1991. Insurers requests for discontinuance, which account for 15% of the total cases, decreased slightly by 271 cases in FY'04. Since the 1991 Reform Act, these requests for discontinuance have decreased by 77%.

Table 9: Breakdown of Total Cases Filed at the DIA, Fiscal Year 2004 and Fiscal Year 2003

Total Cases Filed at the DIA FY'04 and FY'03	Number of Cases		Percentage	
	FY'04	FY'03	FY'04	FY'03
Employee Claims	12,712	14,442	71.7%	73.1%
Insurers Discontinuance Request	2,683	2,954	15.1%	15.0%
Lump Sum Conference Request	1,294	1,658	7.3%	8.4%
Third Party Claims	679	429	3.8%	2.2%
Section 37/37A Request	359	281	2.0%	1.4%
TOTALS:	**17,727**	**19,7640**	**100%**	**100%**

Source: CMS Report 28

CONCILIATION

The first stage of the dispute resolution process is known as the conciliation. The main objective of the conciliation is to remove cases that can be resolved without formal adjudication from the dispute resolution system. At this stage, cases are reviewed for documentation substantiating the positions of both sides of the dispute. Conciliators are empowered to withdraw or reschedule a case until adequate documentation is presented. Although conciliators may encourage the parties to work out a settlement, they have no authority to order the parties to resolve their differences. Approximately 40% of the cases that proceed through conciliation are "resolved" as a result of this process and exit the dispute resolution system. Such resolved cases take on a broad range of dispositions including withdrawals, lump sum settlements, and conciliated cases. The remaining 60% of cases are referred from conciliation to a conference.

The Conciliation Process

Conciliations are scheduled automatically by computer through the Data Processing Unit. Attendance of both the insurer and the employee is required. The employer may attend, as well as other interested parties, with the permission of all parties. All relevant issues (including causal relationship, disability, medical condition, etc.) are reviewed at the meeting.

When liability is not an issue but modification or discontinuance of benefits is sought, both parties are required to submit written settlement offers. If the employee fails to file, the conciliator must record either the last offer made by the employee or the maximum compensation rate. If the insurer fails to file, the conciliator must record the last offer made by them, or record a zero. In an effort to promote compromise, the last, best offer should indicate what each party believes the appropriate compensation rate should be.

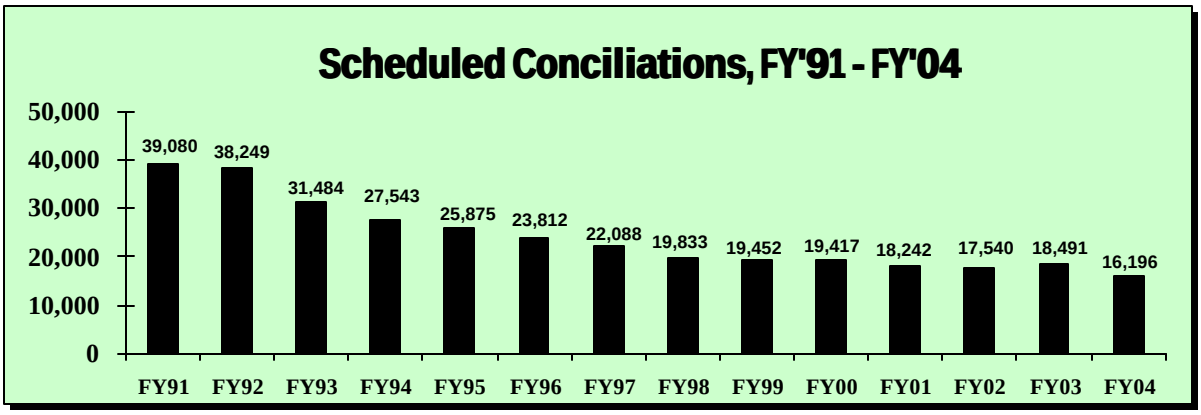
A conciliator's recommendation is written into the case file and the disposition is recorded in the DIA's Case Management System (CMS).

Volume of Scheduled Conciliations

The number of cases reviewed at conciliation is indicative of the total volume of disputed claims, as nearly every case to be adjudicated must first go through conciliation. The caseload of scheduled conciliations peaked in 1991 at 39,080 cases. In FY'04, there were 16,196 cases scheduled for conciliation, which represents a 59% decrease since the Workers' Compensation Reform Act of 1991.

Figure 5 displays the number of cases scheduled for conciliation at the DIA beginning in fiscal year 1991. In fiscal year 2004, the volume of cases scheduled for conciliation decreased by 12% (2,295 cases) from the previous year. It is important to note that many cases scheduled for a conciliation may never actually appear before a conciliator as cases can be withdrawn or adjusted prior to the scheduled meeting.

Figure 5: Volume of Cases Scheduled for Conciliation, FY'91-FY'04

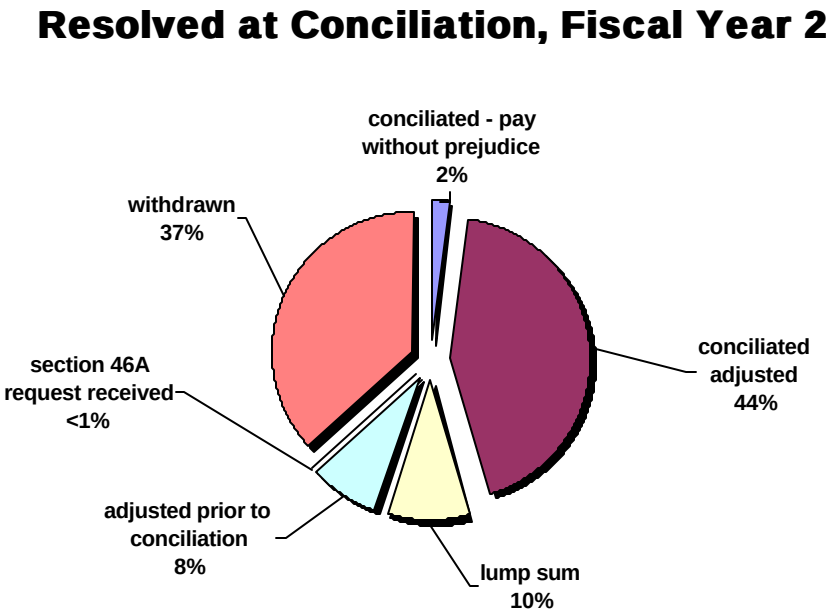


Source: CMS Report 17

Resolved at Conciliation

Disputed cases that are scheduled for a conciliation can be divided into two distinct outcomes: "referred to conference," or "resolved." In FY'04, 7,029 cases were resolved (they were not referred on to a conference) and exited the dispute resolution system. Approximately 40% of cases that are scheduled for a conciliation are resolved while the remaining 60% of cases are referred to conference, the next stage of dispute resolution. As in previous years, a small percentage of the cases scheduled for conciliation are referred to conference without a conciliation taking place. This occurs when the respondent (the party not putting forth the case) does not appear for the conciliation.

Figure 6: Pie-Chart Detailing Cases Resolved at Conciliation, Fiscal Year 2004



Source: CMS Report 17

Table 10: Resolved at Conciliation, Fiscal Year 2004 and Fiscal Year 2003

Resolved at Conciliation FY'04 and FY'03	Number of Cases		Percentage	
	FY'04	FY'03	FY'04	FY'03
Conciliated - Pay Without Prejudice	125	103	1.8%	1.3%
Conciliated Adjusted	3,076	2,896	43.8%	37.9%
Lump Sum	666	713	9.5%	9.3%
Adjusted Prior to Conciliation	566	601	8.1%	7.8%
Section 46A Request Received[6]	3	1	<1%	<1%
Withdrawn	2,593	3,333	36.9%	43.6%
TOTALS:	**7,029**	**7,647**	**100%**	**100%**

Source: CMS Report 17

As displayed in *Table 10*, cases may be conciliated by two methods. Approximately 44% of the resolved cases were "conciliated-adjusted," meaning an agreement was reached at conciliation between the parties to initiate, modify, or terminate the compensation. Secondly, cases may be "conciliated - pay without prejudice" (2% of resolved cases in FY'04), meaning the pay without prejudice period has been extended and the insurer may discontinue compensation without DIA or claimant approval.

The table also indicates that the most prevalent method a case can exit the dispute resolution system at conciliation is through a withdrawal. A case can be withdrawn under various methods. Either before or during the conciliation, the moving party may choose to withdraw the case. A case can also be withdrawn by the agency if the parties either fail to show up for a conciliation or provide the required information.

A case may also be resolved at conciliation utilizing a lump sum settlement. Conciliators are empowered by law to approve lump sum agreements "as complete" but cannot make a determination that the lump sum is in the claimants "best interest." At conciliation, lump sum settlements only account for 10% of the resolved cases at this level of dispute resolution. The percentage of resolved cases that result in a lump sum increase dramatically at both conference and hearing stages.

[6] In fiscal year 2003, the DIA began tracking the "Section 46A Request Received" disposition. Due to the fact that the tracking of this statistic began late in the fiscal year, it is likely that more than one of these request were received during this time period.

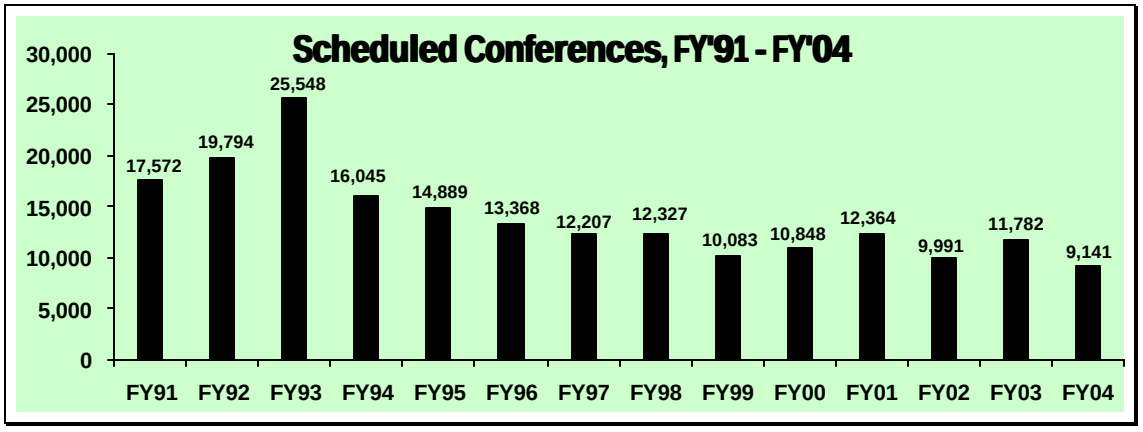
CONFERENCE

The second stage of the dispute resolution process is known as the conference. Each case referred to a conference is assigned an Administrative Judge (AJ) who must retain the case throughout the entire process if possible. The intent of the conference is to compile the evidence and to identify the issues in dispute. The AJ may require injury and medical records as well as statements from witnesses. Although the conference is an informal proceeding, the AJ will issue a binding order shortly after the conference has concluded. This conference order is subject to appeal by the parties. The conference order is a short, written document requiring an AJ's initial impression of compensability, based upon a summary presentation of facts and legal issues at the conference meeting. Conference orders give the parties an understanding as to how the judge might find at a full evidentiary hearing thus providing incentives to pursue settlements or devise return to work arrangements. Approximately 85% of all conference orders in a given fiscal year are appealed to the hearing level of dispute resolution. In the remaining 15% of conference orders, the parties either accept the order or otherwise voluntarily adjust, withdraw or settle the matter.

Volume of Scheduled Conferences

Conferences are scheduled by the Scheduling Unit at the DIA. This occurs after a conciliation has taken place and was unsuccessful at bringing the parties together to reach an agreement on the disputed issues. The number of conferences scheduled in FY'04 decreased by 22% (11,782 in FY'03 to 9,141 in FY'04) from last fiscal year.[7] Each year, the number of conferences scheduled is greater than the number of conferences that will actually take place before an Administrative Judge since many cases are withdrawn or resolved before ever reaching a conference.

Figure 7: Scheduled Conferences, FY'91 - FY'04



Source: CMS Report 45AB (Conference Statistics - For Scheduled Dates)

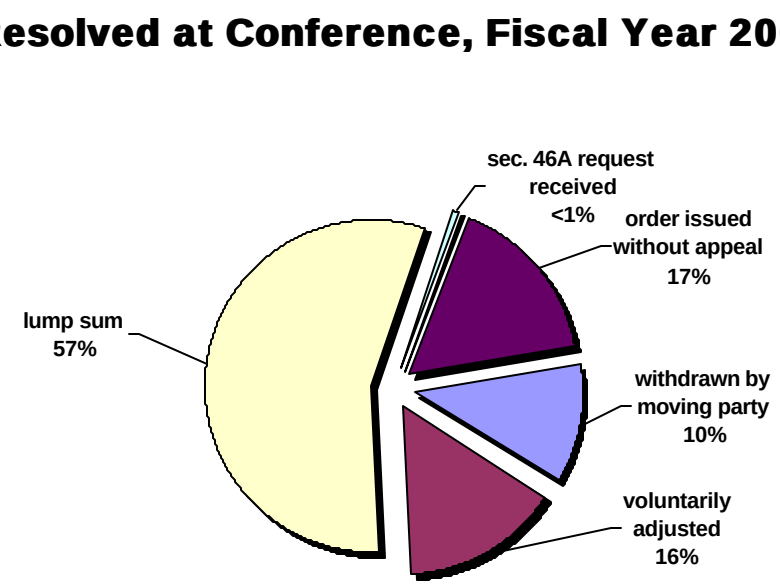
[7] In an effort to avoid duplication, the number of "scheduled conferences" does not include cases that were "rescheduled for a conference." In FY'03, 1,186 cases were "rescheduled for a conference."

Cases Resolved at Conference

Each year, thousands of disputed cases are resolved at the conference level of the dispute resolution process and will not be forwarded to a hearing. In fiscal year 2004, 5,024 cases were resolved at the conference level and exited the dispute resolution system. Although a case may be resolved at the conference level, this does not necessarily mean that the parties appeared before an Administrative Judge. Often a case may be withdrawn before a scheduled conference takes place either by the moving party or by the Administrative Judge. Furthermore, when a case is directed to a lump sum conference or is voluntarily adjusted, it may never actually reach the scheduled conference.

Figure 8 and *Table 11* display the various methods a disputed case can be resolved at conference.

Figure 8: Pie-Chart Detailing Cases Resolved at Conference, Fiscal Year 2004



Source: CMS Reports 434, 319AB, 476A, 431

Table 11: Cases Resolved at Conference, Fiscal Year 2004 and Fiscal Year 2003

Resolved at Conference FY'04 and FY'03	Number of Cases		Percentage	
	FY'04	FY'03	FY'04	FY'03
Withdrawn by Moving Party	522	703	10.4%	11.9%
Voluntarily Adjusted	789	995	15.7%	16.8%
Lump Sum	2,858	3,005	56.9%	50.7%
Section 46A Request Received	16	4	<1%	<1%
Order Issued Without Appeal	839	1,219	16.7%	20.6%
Total	**5,024**	**5,926**	**100%**	**100%**

Source: CMS Reports 434, 319AB, 476A, 431

As displayed in *Table 11* there are various methods by which a disputed case can be resolved at the conference level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2004, 522 cases (10% of resolved cases at conference) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the conference when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2004, 789 cases (16% of resolved cases at conference) were voluntarily adjusted.

The most prevalent method in which a case exits the system at the conference level is through a lump sum settlement. Lump sum settlements may be approved either at a conference or a separate lump sum conference. The procedure is the same for both meetings. In some instances, the presiding AJ will hear the lump sum, while in others, an assigned ALJ will hear the case on a lump sum list. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. In fiscal year 2004, 2,858 cases (57% of resolved cases at conference) exited the system through a lump sum.

Another method in which a case could exit the system is if a "Section 46A Request" is filed when there is an outstanding lien on a case that has been deemed compensable. A "Section 46A Request" occurs in conjunction with a lump sum settlement. The case is required to appear before an Administrative Law Judge (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2004, only 16 of these request have been documented.

Finally, the most obvious method in which a case can exit the system at the conference level is when the presiding Administrative Judge issues a conference order and it is not appealed by any of the parties to the hearing level. In fiscal year 2004, 839 conference orders (17% of resolved cases at conference) were issued by Administrative Judges, not resulting in an appeal. However, the vast majority of conference orders are appealed to the hearing stage of dispute resolution. In fiscal year 2004, 6,448 conference orders (87% of all conference orders) were appealed to a hearing. [8]

Table 12: Conference Orders, FY'04 - FY'00

Conference Orders FY'04 - FY'00	Total Orders	Appealed	Without Appeal
Fiscal Year 2004	**6,448**	5,609 (87.0%)	839 (13.0%)
Fiscal Year 2003	**7,899**	6,680 (84.6%)	1,219 (15.4%)
Fiscal Year 2002	**6,802**	5,841 (85.9%)	961 (14.1%)
Fiscal Year 2001	**8,486**	7,361 (86.7%)	1,125 (13.2%)
Fiscal Year 2000	**7,570**	6,516 (86.1%)	1,054 (13.9%)

Source: CMS Reports 319AB, "Appealed Conference Order Statistics."

[8] CMS Report 319AB, "Appealed Conference Order Statistics."

Conference Queue

The Senior Judge has explained that, depending on the number of available judges, a conference queue of between 1,500 and 2,000 cases can effectively be scheduled during the judges' regular cycles. If the queue increases beyond 2,000 cases, adjustments in scheduling and assignments would need to occur.

As *Figure 10* shows below, the conference queue increased significantly in FY'04 due to a scheduling cycle that focused on decreasing the backlog of hearings. In FY'04 the conference queue ended 1,608 cases above the start of the year (568 on 7/2/03 and 2,176 on 6/30/04). The conference queue reached a high of 2,176 on 6/30/04 and a low of 568 on 7/2/03.

Figure 9: Conference and Hearing Queues; Fiscal Years 1991 - 2004

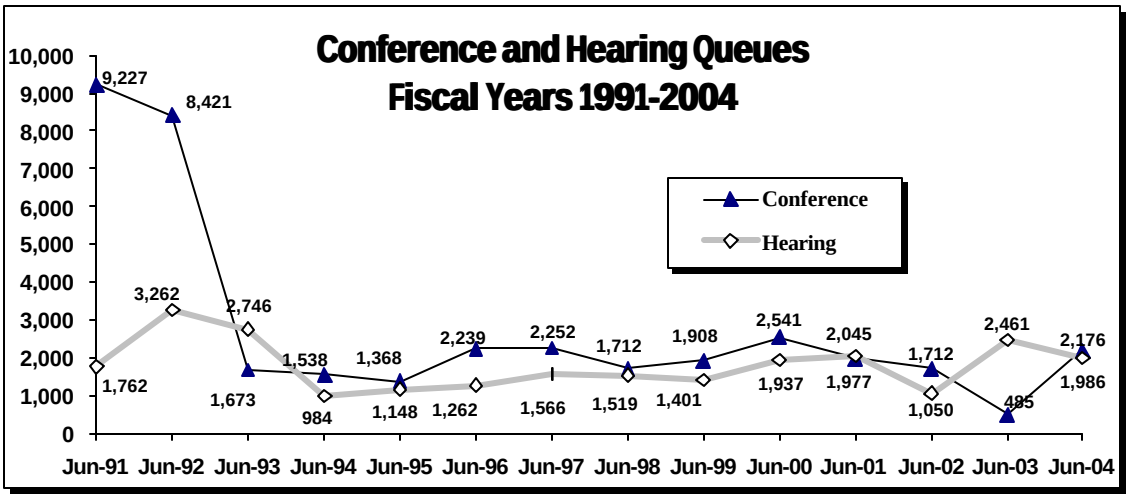
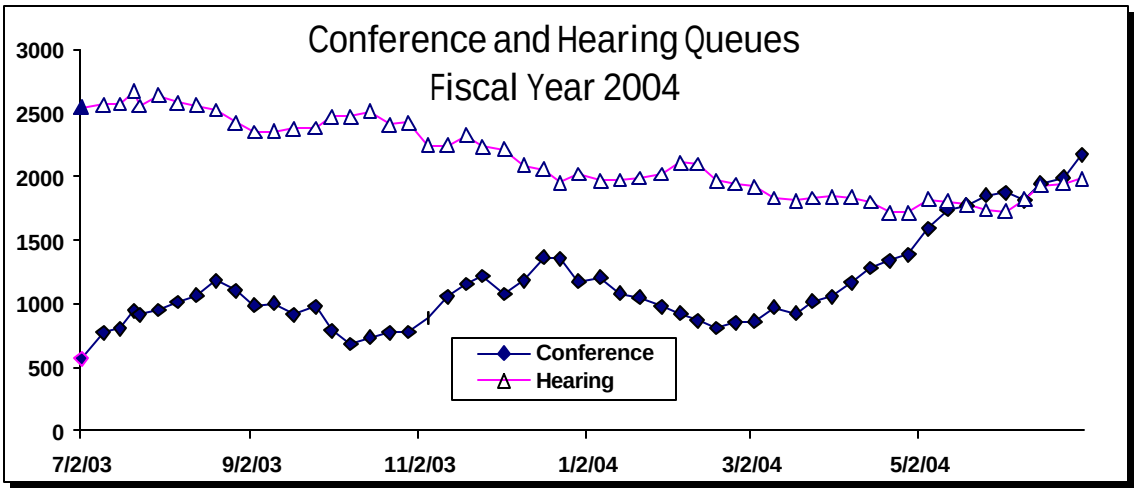


Figure 10: Conference and Hearing Queue; Fiscal Year 2004



Source: CMS Report 404

HEARINGS

The third stage of the dispute resolution process is known as the hearing. According to the Workers' Compensation Act, an Administrative Judge that presides over a conference must review the dispute at the hearing level, unless scheduling becomes "impractical." The procedure is formal and a verbatim transcript of the proceedings is recorded. Written documents are presented and witnesses are examined and cross-examined, in accordance with the Massachusetts Rules of Evidence. If the parties are disputing medical issues, an impartial physician will be selected from a DIA roster before the hearing takes place so that an Impartial Medical Examination (IME) of the injured employee can occur. At the hearing, the impartial physician's report is the only medical evidence that can be presented unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed in the report. Any party may appeal a hearing decision within 30 days. This appeal time may be extended up to one year for reasonable cause. A fee of 30% of the state average weekly wage must accompany the appeal. The claim will then be forwarded to the Reviewing Board.

Hearing Queue

Much like conferences, hearings are scheduled by the Scheduling Unit at the DIA. This occurs after a conference has taken place and the judge's order has been appealed by any party. The scheduling of hearings is more difficult than conferences because the hearing must be assigned to the judge who heard the case at the conference level. This is especially problematic since judges have different conference appeal rates. A judge with a high appeal rate will generate more hearings than a judge with a low rate of appeal. This can create difficulty in evenly distributing cases, since hearing queues may occur for individual judges with high appeal rates.

It is difficult to compare the hearing queue with the conference queue because of the differences in the two proceedings. Hearings must be scheduled with the same judge who presided over the conference, whereas conferences are scheduled according to availability (when "judge ownership" is not yet a factor). Since hearings are also more time consuming than conferences, it takes more time to handle a hearing queue than a conference queue. Fiscal year 2004 began with a hearing queue of 2,545 and ended at 1,986. In the last fifteen years, the hearing queue has been as low as 409 cases in September 1989 and as high as 4,046 in November 1992.

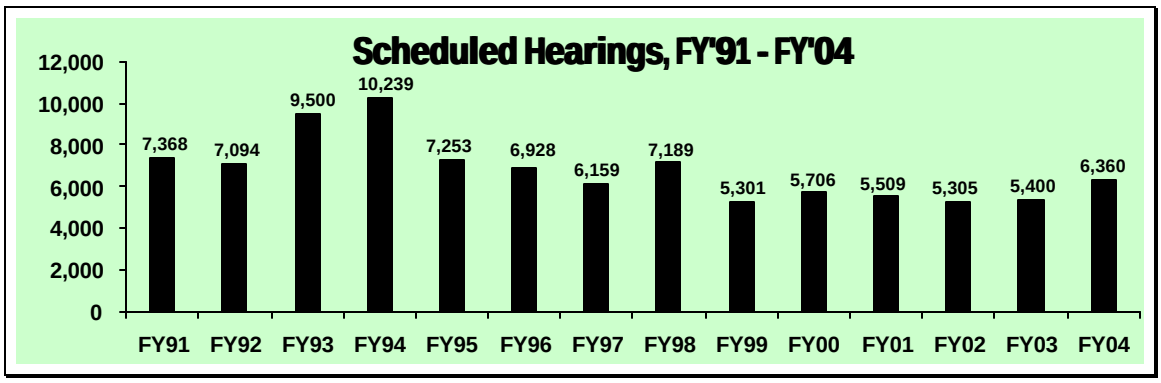
Volume of Scheduled Hearings

The number of hearings scheduled in FY'04 increased by 960 cases (5,400 in FY'03 to 6,360 in FY'04) from last fiscal year.[9] Each year, the number of hearings scheduled is greater than the number of hearings that will actually take place before an Administrative Judge since many cases are withdrawn or resolved before ever reaching a hearing.

[9] In an effort to avoid duplication, the number of "scheduled hearings" does not include cases that were "rescheduled for a hearing." In FY'04, 2,822 cases were "rescheduled for a hearing."

The following chart shows how the number of "scheduled hearings" increased by 18% from last fiscal year.

Figure 11: Scheduled Hearings, FY'91 - FY'04

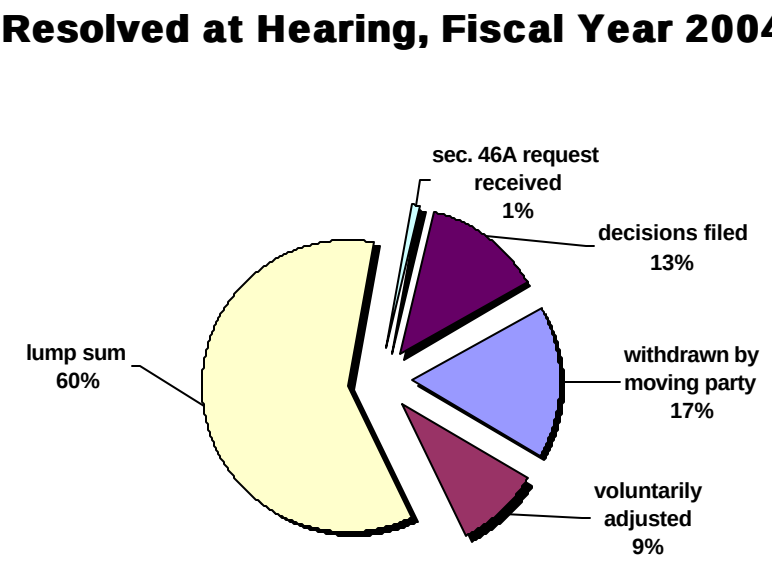


Source: CMS Report 46 (Hearing Statistics - For Scheduled Dates)

Cases Resolved at Hearing

In fiscal year 2004, 5,694 cases were resolved at the hearing level. It is important to note that a case resolved at the hearing level does not necessarily exit the system as the parties have 30 days from the decision date to appeal a case to the reviewing board. Much like conferences, a case resolved at the hearing level does not mean that the case made it to the actual hearing as it may be withdrawn, voluntarily adjusted or a lump sum could occur prior to the proceeding. The following pie-chart and statistical table shows the various methods by which a disputed case can be resolved at hearing.

Figure 12: Pie-Chart Detailing Cases Resolved at Hearing, Fiscal Year 2004



Source: CMS Report 431

Table 13: Cases Resolved at Hearing, Fiscal Year 2004 and Fiscal Year 2003

Resolved at Hearing FY'04 and FY'03	Number of Cases		Percentage	
	FY'04	FY'03	FY'04	FY'03
Withdrawn by Moving Party	967	811	17.0%	16.5%
Voluntarily Adjusted	530	587	9.3%	11.9%
Lump Sum	3,418	2,868	60.0%	58.3%
Section 46A Request Received	57	13	1.0%	<1%
Decisions Filed	722	643	12.7%	13.1%
Total	**5,694**	**4,922**	**100%**	**100%**

Source: CMS Report 431

As displayed in *Table 13*, there are various methods by which a disputed case can be resolved at the hearing level. First, the moving party may decide to withdraw the case completely from the system. In fiscal year 2004, 967 cases (17% of resolved cases at hearing) exited the system in this manner.

Second, the parties may agree to have the case voluntarily adjusted. This occurs at the hearing when a compromise on any part of the case (benefit level, benefit duration, etc.) can be reached among the parties. In fiscal year 2004, 530 cases (9% of resolved cases at hearing) were voluntarily adjusted.

Much like at the conference level, the most prevalent method by which a case exits the system at the hearing level is through a lump sum settlement. Lump sum settlements may be approved either at a hearing or at a separate lump sum conference. The procedure is the same for both meetings. Most lump sum settlements are approved directly at the conference or the hearing level by the presiding AJ, rather than scheduling a separate meeting. In fiscal year 2004, 3,418 cases (60% of resolved cases at hearing) exited the system through a lump sum settlement.

Another method in which a case could exit the system is if a "Section 46A Request" is filed when there is an outstanding lien on a case that has been deemed compensable. A "Section 46A Request" occurs in conjunction with a lump sum settlement. The case is required to appear before an Administrative Law Judge (ALJ) to determine if reimbursement is owed out of the proceeds of the award. In fiscal year 2004, only 57 of these request have been documented at the hearing level.

Finally, the most obvious method by which a case can exit the system at the hearing level is when the presiding Administrative Judge issues a hearing decision. In fiscal year 2004, 722 hearing decisions (13% of resolved cases at hearing) were filed by Administrative Judges.

REVIEWING BOARD

The fourth and final possible stage of dispute resolution at the DIA is known as the reviewing board. The reviewing board consists of six Administrative Law Judges (ALJ's) whose primary function is to review the appeals from hearing decisions. While appeals are heard by a panel of three ALJ's, initial pre-transcript conferences are held by individual ALJ's. The Administrative Law Judges also work independently to perform three other statutory duties: preside at lump sum conferences, review third party settlements (§15), and discharge and modify liens against an employee's lump sum settlement (§46A).

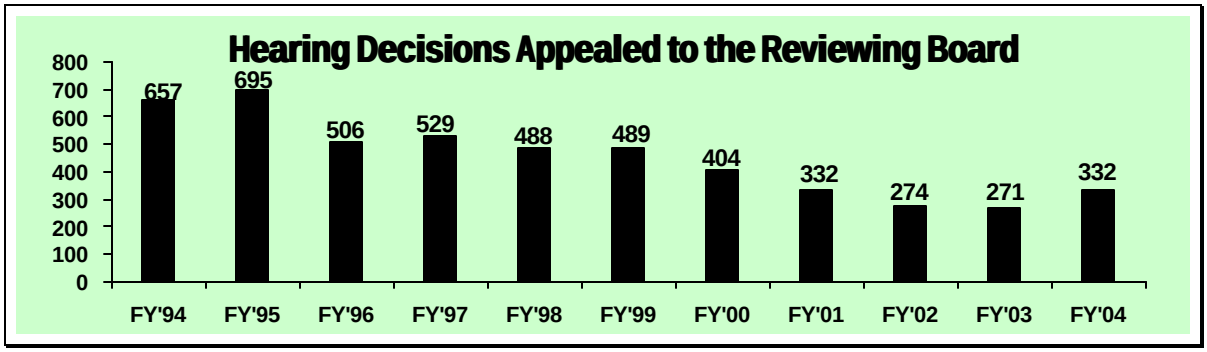
Volume of Hearing Decisions Appealed to the Reviewing Board

An appeal of a hearing decision must be filed with the Reviewing Board no later than 30 days from the date of the decision. A filing fee of 30% of the state's average weekly wage, or a request for waiver of the fee, based on indigence, must accompany any appeal.

Pre-transcript conferences are held before a single ALJ to identify and narrow the issues, to determine if oral argument is required and to decide if producing a transcript is necessary. This is an important step that can clarify the issues in dispute and encourage some parties to settle or withdraw the case. Approximately 20% to 25% of the cases are withdrawn or settled following this first meeting. After the pre-transcript conference, the parties are entitled to a verbatim transcript of the appealed hearing.

Ultimately, cases that are not withdrawn or settled proceed to a panel of three ALJ's. The panel reviews the evidence presented at the hearing, as well as any findings of law made by the AJ. The appellant must file a brief in accordance with the board's regulations and the appellee must also file a response brief. An oral argument may be scheduled. The vast majority of cases are remanded for further findings of fact and/or review of conclusions of law. However, the panel may reverse the Administrative Judge's decision only when it determines that the decision was beyond the AJ's scope of authority, arbitrary or capricious, or contrary to law. The panel is not a fact-finding body, although it may recommit a case to an AJ for further findings of fact. The number of hearing decisions appealed to the Reviewing Board in fiscal year 2004 was 332.

Figure 13: Hearing Decisions Appealed to the Reviewing Board, FY'94 - FY'04



Source: CMS Report 46 (Hearing Statistics - For Scheduled Dates)

The Reviewing Board resolved 250 cases in FY'04 (some from the prior year) compared to 311 in the previous fiscal year.

Figure 14: Appeals Resolved at the Reviewing Board, Fiscal Year 2004

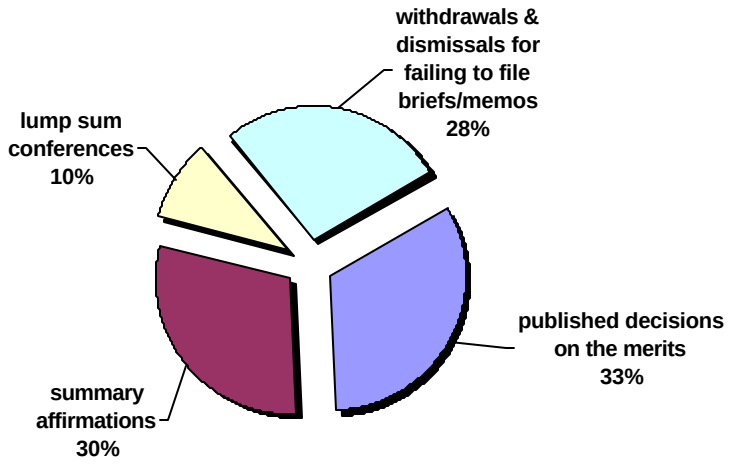


Table 14: Appeals Resolved at the Reviewing Board, Fiscal Year 2004

Appeals Resolved at the Reviewing Board, FY'04	*Number of Cases*
Published Decision on the Merits (Full Panel):	83 (33.2%)
Summary Affirmations (After Full Panel Deliberation):	74 (29.6%)
Lump Sum Conferences:	24 (9.6%)
Withdrawals/Dismissals for Failing to File Briefs/Memos:	69 (27.6%)
Total Number of Appeals Resolved by the Reviewing Board:	**250 (100%)**

Source: DIA Reviewing Board

Lump Sum Conferences

The purpose of the lump sum conference is to determine if a settlement is in the best interest of the employee. A lump sum conference may be requested at any point during the dispute resolution process upon agreement of both the employee and insurer. Lump sum conferences are identical to the approval of settlements by Administrative Judges at the conference and hearing. Conciliators may refer cases to this lump sum conference at the request of the parties or the parties may request a lump sum conference directly.

Third Party Subrogation (§15)

When a work-related injury results in a legal liability for a party other than the employer, a claim may be brought against the third party for payment of damages. The injured employee may collect workers' compensation indemnity and health care benefits under the employer's insurance policy, and may also file suit against the third party for damages. For example, an injury sustained by an employee, as the result of a motor vehicle accident in the course of a delivery, would entitle the employee to workers' compensation benefits. The accident, however, may have been caused by another driver not associated with the employer. In this case, the employee could collect workers' compensation benefits and simultaneously bring suit against the other driver for damages.

Monies recovered by the employee in the third party action must be reimbursed to the workers' compensation insurer. However, any amounts recovered that exceed the total amount of benefits paid by the insurer may be retained by the employee.

The statute provides that the Reviewing Board may approve a third party settlement. A hearing must be held to evaluate the merits of the settlement, as well as the fair allocation of amounts payable to the employee and the insurer. Guidelines were developed to ensure that due consideration is given to the multitude of issues that arise from settlements. During FY'04, Administrative Law Judges heard 1,122 Section 15 petitions on a rotating basis.

Compromise and Discharge of Liens (§46A)

Administrative Law Judges are also responsible to determine the fair and reasonable amount to be paid out of lump sum settlements to discharge liens under M.G.L. c.152, §46A.

A health insurer or hospital providing treatment may seek reimbursement under this Section for the cost of services rendered when it is determined that the treatment provided arose from a work related injury. The Commonwealth's Department of Transitional Assistance can make a similar claim for reimbursement after providing assistance to an employee whose claim has subsequently been determined to be compensable under the workers' compensation laws.

In those instances, the health insurer, hospital, or Department of Transitional Assistance may file a lien against either the award for benefits or the lump sum settlement. When a settlement is proposed and the employee and the lien-holder are unable to reach an agreement, the ALJ must determine the fair and reasonable amount to be paid out of the settlement to discharge the lien.

The number of Section 46A conferences heard in fiscal year 2004 was 103.

ADMINISTRATIVE JUDGES

DIA Administrative Judges (AJs) and Administrative Law Judges (ALJs) are appointed by the Governor, with the advice and consent of the Governor's Council. Candidates for the positions are first screened by the Industrial Accidents Nominating Panel [see Appendix D for membership] and then rated by the Advisory Council. M.G.L. c.23E allows for the appointment of 21 Administrative Judges, 6 Administrative Law Judges, and as many former judges to be recalled as the Governor deems necessary.

As one management tool to maintain a productive staff, the Senior Judge may stop assigning new cases to any judge with an inordinate number of hearing decisions unwritten. Intended as a sanction, it provides a judge who has fallen behind with the opportunity to catch up. This could become problematic if a large queue of new cases were to develop. The administrative practice of taking a judge off-line is relatively rare and occurs for a limited time period. However, the Senior Judge may take an AJ off-line near the end of a term until reappointment is made. This enables the judges to complete their assigned hearings, thereby, minimizing the number of cases that must be re-assigned to other judges after their term expires.

Appointment Process

Nominating Panel - The Nominating Panel is comprised of thirteen members as designated by statute. When a judicial position becomes available, the Nominating Panel convenes to review applications for appointment and reappointment. The panel considers an applicant's skills in fact finding and the understanding of anatomy and physiology. In addition, an AJ must have a minimum of a college degree or four years of writing experience and an ALJ must be a Massachusetts attorney (or formerly served as an AJ). Consideration for reappointment includes review of a judge's written decisions, as well as the Senior Judge's evaluation of the applicant's judicial demeanor, average time for disposition of cases, total number of cases heard and decided, and appellate record.

On December 18, 2003, the appointment process was revised when Governor Romney signed Executive Order #456. The main objective of the Executive Order was to strengthen the selection process to ensure that all applicants who apply for a judgeship have their qualifications reviewed on merit. The Executive Order increased confidentiality during the deliberation process and created a Code of Conduct for both applicants and members of the Nominating Panel.

Advisory Council Review - Upon the completion of the Nominating Panel's review, recommended applicants are forwarded to the Advisory Council. The Advisory Council will review these candidates either through a formal interview or by a "paper review." On the affirmative vote of at least seven voting members, the Advisory Council may rate any candidate as either "qualified," "highly qualified," or "unqualified." This rating must then be forwarded to the Governor's Chief Legal Counsel within one week from the time a candidate's name was transmitted to the Council from the Nominating Panel (see Appendix J for a complete description of the Advisory Council's interview guidelines).

LUMP SUM SETTLEMENTS

A lump sum settlement is an agreement between the employee and the employer's workers' compensation insurer, whereby the employee will receive a one-time payment in place of weekly compensation benefits. In most instances, the employer must ratify the lump sum settlement before it can be implemented. While settlements close out indemnity payments for lost income, medical and vocational rehabilitation benefits must remain open and available to the employee if needed.

Lump sum settlements can occur at any point in the dispute resolution process, whether it is before the conciliation or after the hearing. Conciliators have the power to "review and approve as complete" lump sum settlements that have already been negotiated. Administrative Judges may approve lump sum settlements at conference and hearings just as an ALJ does at a lump sum conference. At the request of the parties, conciliators and Administrative Judges may also refer the case to a separate lump sum conference where an Administrative Law Judge will decide if it is in the best interest of the employee to settle.

Table 15: Lump Sum Conference Statistics, FY'04-FY'91

Fiscal Year	*Total lump sum conferences scheduled*	*Lump sum settlements approved*
FY'04	**8,442**	**7,754 (91.9%)**
FY'03	7,887	7,738 (95.7%)
FY'02	8,135	7,738 (95.1%)
FY'01	8,111	7,801 (96.2%)
FY'00	8,297	7,940 (95.7%)
FY'99	7,900	7,563 (95.7%)
FY'98	9,579	9,158 (95.6%)
FY'97	9,293	8,770 (94.4%)
FY'96	10,047	9,633 (95.9%)
FY'95	10,297	9,864 (95.8%)
FY'94	13,605	12,578 (92.5%)
FY'93	17,695	15,762 (89.1%)
FY'92	18,310	16,019 (87.5%)
FY'91	19,724	17,297 (87.7%)

Source: CMS Report 86: Lump Sum Conference Statistics for Scheduled Dates

The number of lump sum conferences scheduled has declined by 57% since FY'91. In FY'04, only 7 lump sum settlements were disapproved in the whole fiscal year. The remainder of the scheduled lump sum conferences without an "approved" disposition were either withdrawn or rescheduled.

There are four dispositions that indicate a lump sum settlement occurred for conciliations, conferences, and hearings:

Lump Sum Reviewed - Approved as Complete - Pursuant to §48 of Chapter 152, conciliators have the power to "review and approve as complete" lump sum settlements when both parties arrive at conciliation with a settlement already negotiated.

Lump Sum Approved - Administrative Judges at the conference and hearing may approve settlements, and just as an ALJ at a lump sum conference, they must determine if the settlement is in the best interest of the employee.

Referred to Lump Sum - Lump sums settlements may also be reviewed at a lump sum conference conducted by an assigned ALJ. Conciliators and Administrative Judges may refer cases to lump sum conferences to determine if settlement is in the best interest of the employee. Many lawyers prefer to have a case referred to a lump sum conference rather than have a conciliator approve a settlement. An ALJ renders a judgment regarding the adequacy and appropriateness of the settlement amount, whereas a conciliator merely approves the agreement "as complete." Most attorneys want their client's settlement reviewed and determined by a judge to be in their "best interest."

Lump Sum Request Received - A lump sum conference may also be requested after a case has been scheduled for a conciliation, conference, or hearing. The parties would fill out a form to request this event and the disposition would then be recorded as "lump sum request received." Lump sum conferences may also be requested without scheduling a meeting.

Lump sum settlement dispositions become increasingly prevalent at the later stages of the dispute resolution process as indicated in the table below.

Table 16: Lump Sum Settlements Pursued at Each Level of Dispute Resolution - FY'04

Fiscal Year 2004	*Lump Sum Pursued*[10]	*% Total Cases Resolved (at each level of dispute)*
Conciliation	666	9.5%
Conference	2,858	56.9%
Hearing	3,418	60.0%

Source: See Previous Sections on Conciliations, Conferences, and Hearings.

[10] Lump sum pursued refers to four dispositions for lump sum settlements: lump sum request received; lump sum reviewed-approved as complete; lump sum approved; referred to lump sum conference.

IMPARTIAL MEDICAL EXAMINATIONS

The impartial medical examination has become a significant component of the dispute resolution process, since it was created by the Reform Act of 1991. During the conciliation and conference stages, a disputed case is guided by the opinions of the employee's treating physician and the independent medical report of the insurer. Once a case is brought before an Administrative Judge at a hearing, however, the impartial physician's report is the only medical evidence that can be presented. Any additional medical testimony is inadmissible, unless the judge determines the report to be "inadequate" or that there is considerable "complexity" of the medical issues that could not be fully addressed by the report.

The 1991 reforms were designed to solve the problem of "dueling doctors," which frequently resulted in the submission of conflicting evidence by employees and insurers. Prior to 1991, judges were forced to make medical judgments by weighing the report of an examining physician, retained by the insurer, against the report of the employee's treating physician.

Section 11A of the Workers' Compensation Act now requires that the Senior Judge periodically review and update a roster of impartial medical examiners from a variety of specialized medical fields. When a case involving disputed medical issues is appealed to hearing, the parties must agree on the selection of an impartial physician. If the parties cannot agree, the AJ must appoint one. An insurer may also request an impartial examination if there is a delay in the conference order.[11] Furthermore, any party may request an impartial exam to assess the reasonableness or necessity of a particular course of medical treatment, with the impartial physician's opinion binding the parties until a subsequent proceeding. Should an employee fail to attend the impartial medical examination, they risk the suspension of benefits.[12]

Under Section 11A, the impartial medical examiner must determine whether a disability exists, whether such disability is total, partial, temporary or permanent, and whether such disability has as its "major or predominant contributing cause" a work-related personal injury. The examination should be conducted within 30 to 45 calendar days from assignment. Each party must receive the impartial report at least 7 days prior to the start of a hearing.

Impartial Unit

The Impartial Unit, within the DIA's Division of Dispute Resolution, will choose a physician from the impartial physician roster when parties have not selected one or when the AJ has not appointed one. While it is rare that the Impartial Unit chooses the specialty, in most cases it must choose the actual physician. The unit is also required to collect filing fees, schedule examinations, and to ensure that medical reports are promptly filed and that physicians are compensated after the report is received.

[11] M.G.L. c.152, §8(4).
[12] M.G.L. c.152, §45.

Filing fees for the examinations are determined by the Commissioner and set by regulation through the Commonwealth's Executive Office of Administration & Finance.

The following details the DIA's fee schedule:

Table 17: Fee Schedule - Impartial Medical Examinations

$450	Impartial medical examination and report
$500	For deposition lasting up to 2 hours
$100	Additional fee when deposition exceeds 2 hours
$225	Review of medical records only
$125	Supplemental medical report
$100	When worker fails to keep appointment (maximum of 2)
$100	For cancellation less than 24 hours before exam

Source: DIA Medical Unit
Note: Fee Schedule is subject to increase.

The deposing party is responsible for paying the impartial examiner for services and the report. Should the employee prevail at hearing, the insurer must pay the employee the cost of the deposition. In FY'04, approximately $1,916,900 was collected in filing fees.

As of 6/30/04, there were 258 physicians on the roster consisting of 27 specialties. [13] The impartial unit is responsible for scheduling appointments with the physicians. Scheduling depends upon the availability of physicians, which varies by geographic region and the specialty sought. A queue for scheduling may arise according to certain specialties and regions in the state.

In FY'04 the impartial unit scheduled 6,844 examinations. Of these, 4,814 exams were actually conducted in the fiscal year (the remainder of the scheduled exams were either canceled due to settlements and withdrawals or took place in the next year). [14] Medical reports are required to be submitted to the Division and to each party within 21 calendar days after completion of the examination. The number of exams scheduled in FY'03 was 7,151 and 4,521 were conducted in that year.

Impartial Exam Fee Waiver for Indigent Claimants

In 1995, the Supreme Judicial Court ruled that the Division of Industrial Accidents must waive the filing fee for indigent claimants appealing an Administrative Judge's benefit-denial order. As a result of this decision, the DIA has implemented procedures and standards for processing waiver requests and providing financial relief for the Section 11A fee.

[13] Including contracts pending renewal.
[14] Additional reports may be entered upon FY'04 closure.

The Waiver Process - A workers' compensation claimant who wishes to have the impartial examination fee waived must complete the form "Affidavit of Indigence and Request for Waiver of §11A (2) Fees" (Form 136). This document must be completed before 10 calendar days following the appeal of a conference order.

It is within the discretion of the Commissioner to accept or deny a claimant's request for a waiver, based on documentation supporting the claimant's assertion of indigency as established in 452 CMR 1.02. If the Commissioner denies a waiver request, it must be supported by findings and reasons in a Notice of Denial report. Within 10 days of receipt of the Notice of Denial report, a party can request a reconsideration. The Commissioner can deny this request without a hearing if past documentation does not support the definition of "indigent" set out in 452 CMR 1.02, or if the request is inconsistent or incomplete. If a claimant is granted a waiver and prevails at a hearing, the insurer must reimburse the Division for any fees waived.

An indigent party is defined as:

a) one who receives one of the following types of public assistance: Aid to Families with Dependent Children (AFDC), Emergency Aid to Elderly Disabled and Children (EAEDC), poverty related veteran benefits, food stamps, refugee resettlement benefits, Medicaid, or Supplemental Security Income (SSI) or;

b) one whose annual income after taxes is 125% of the current federal poverty threshold (established by the U.S. Department of Health and Human Services) as referred to in M.G.L. c.261, §27A(b). Furthermore, a party may be determined indigent based on the consideration of available funds relative to the party's basic living costs.

Table 18: DIA Indigency Requirements, 2004

2004 HHS Poverty Guidelines	
Size of Family Unit	**Amount***
1	$9,310
2	$12,490
3	$15,670
4	$18,850
5	$22,030
6	$25,210
7	$28,390
8	$31,570

For family units with more than eight members, add $3,180 for each additional member in the family. The poverty guidelines are updated annually by the U.S. Department of Health and Human Services.

SOURCE: *Federal Register*, Vol. 69, No. 30, February 13, 2004, pp. 7,336-7,338.
*48 Contiguous States and D.C.

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OFFICE OF CLAIMS ADMINISTRATION

The Office of Claims Administration (OCA) is responsible for reviewing, maintaining and recording the massive number of forms the DIA receives on a daily basis, as well as for ensuring that claims forms are processed in a timely and accurate manner. Quality control is a priority of the office and it is essential to ensure that each case is recorded in a systematic and uniform method.

The OCA consists of the Claims Processing Operations Unit, the Record Room, and the Administrative Office (which includes the Keeper of Records and First Report Compliance). The Manager of Claims Administration is responsible for overseeing the operations of each unit within the Office of Claims Administration.

Claims Processing Operations Unit

The Claims Processing Operations Unit is responsible for the intake and entry of all mail, including electronic filings that come into the OCA.[15] The OCA reviews each form, ensuring they are complete and accurate. Any incomplete or inaccurate form is returned to the sender. Reports, transactions, and other relevant data are entered into the DIA's Oracle database. As data entry personnel update the computerized records with new forms, they also review the entire record to ensure that duplicate forms are not contained in the database, as well as to make certain that all necessary information has been entered properly for quality assurance.

While quality control measures slow down the process, they are necessary for accurate and complete record keeping. Forms are entered in order of priority, with the need for scheduling at dispute resolution as the main objective. All conciliations are scheduled upon entry of a claim through the Oracle Case Management System (CMS). Information entered into CMS generates violation notices, scheduling of conciliations and judicial proceedings, and statistical reports. The DIA and other agencies use this data to facilitate various administrative and law enforcement functions.

In fiscal year 2004, the Office of Claims Administration received 36,739 First Report of Injury Forms, 98 more than FY'03 (36,641). The number of claims, discontinuances and third party claims received by the office decreased by 574 to 19,846. The total number of referrals to conciliation for the fiscal year was 16,394, which represents an 8% decrease from last fiscal year (17,826).

Record Room

The record room, located in the DIA's Boston office, is the central repository for all departmental case files and transactions. The Record Room staff is responsible for filing, maintaining, storing, retrieving and tracking all files pertaining to a case in the dispute resolution process. Included in case files are copies of all briefs, settlement offers,

[15] Online filing submissions of the First Report of Injury (Form 101) became effective at the DIA in April of 2003.

medical records, and supporting documentation that accumulate during the dispute resolution process. Couriers transfer files between the regional office and the Boston office twice a week.

The DIA files have a retention cycle of 40 years, 32 at the state archive and 8 years on-site. In addition to the DIA's main Record Room, a mini archive area containing 2,000 boxes of quality files are located within the agency. The Record Room obtained space in the DIA's Lawrence Office to serve as a supplemental storage facility. Complex file management procedures, in accordance with State Record Center (SRC) regulations, are the key to maintaining information that is accessible and easy to transfer upon request.

Administrative Office

OCA's Administrative Office serves as Keeper of Records and requests for workers' compensation file copies and other public information pursuant to the Massachusetts Public Records Law. Those seeking information, data and specific records include employees (past and current injured workers), attorneys, insurers, investigative and pre-employment services, as well as law enforcement agencies. The trend in public records request continue to rise and the number of these requests grow unabated. The Administrative Office also processes subpoenas, holding in-house depositions. A fee charge is billed to the requestors for copies, labor and research. The Office also assists the Insurance Fraud Bureau, Attorney General's Office and other governmental agencies.

First Report Compliance Office

All Employers must report any injury alleged to have arisen out of and in the course of employment that incapacitates an employee from earning full/partial wages for a period of five or more calendar days. Failure to file a First Report or a late First Report is a violation of M.G.L. c.152, §6. If an Employer violates this provision three or more times within any year, they shall be punished by a fine of one hundred dollars ($100) for each such violation. Each failure to pay a fine within thirty days of receipt of a bill from the DIA shall be considered a separate violation and thus, escalates, to the next demand level until a referral to a collection agency.

In fiscal year 2004, $235,580 was collected in fines, a moderate increase from the $173,152 collected in FY'03.[16] The office is also responsible for maintaining a database on cases discovered by the DIA, where there may be suspicion of fraud. In fiscal year 2004, the Office of Claims Administration received eleven (11) in-house referrals (telephone calls, anonymous letters or within DIA units via CMS). Outside referrals are directly reported to the Insurance Fraud Bureau or the Attorney General's Office. Claims Administration assists the Insurance Fraud Bureau investigators on copies of suspected workers' compensation files, and receives status update letters. A total of 52 such inquiries were processed during FY'04.

[16] A CMS Program glitch from May 2002 to October 2002 prevented monthly First Report fines to be generated. This problem was corrected in November of 2002 and 700 bills were generated from the backlog.

OFFICE OF EDUCATION AND VOC. REHAB

The Office of Education and Vocational Rehabilitation (OEVR) oversees the rehabilitation of disabled workers' compensation recipients with the ultimate goal of successfully returning them to employment.

While OEVR seeks to encourage the voluntary development of rehabilitation services, it has the authority to mandate services for injured workers determined to be suitable for rehabilitation. Vocational rehabilitation (VR) is defined by the Act as "non-medical services reasonably necessary at a reasonable cost to restore a disabled employee to suitable employment as near as possible to pre-injury earnings. Such services may include vocational evaluation, counseling, education, workplace modification, and retraining, including on-the-job training for alternative employment with the same employer, and job placement assistance. It shall also mean reasonably necessary related expenses."[17]

A claimant is eligible for vocational rehabilitation services when an injury results in a functional limitation prohibiting a return to previous employment, or when the limitation is permanent or will last an indefinite period of time. Liability must be established in every case and the claimant must be receiving benefits.

Vocational Rehabilitation Specialist

Each year, OEVR approves vocational rehabilitation specialists to develop and implement the individual written rehabilitation plans (IWRP). The standards and qualifications for a certified provider are found in the regulations, 452 C.M.R. §4.03. Any state vocational rehabilitation agency, employment agency, insurer, self-insurer, or private vocational rehabilitation agency may qualify to perform these services. All Request for Response (RFR) information, including application forms, are now available through the DIA website.

Credentials must include at least a master's degree, rehabilitation certification, or a minimum of 10 years of experience. A list of the providers is available from OEVR. In FY'04, OEVR approved 61 VR providers. It is the responsibility of the provider to submit progress reports on a regular basis, so that OEVR's Rehabilitation Review Officers (RROs) can have a clear understanding of the case's progress. Progress reports must include the following:

1. Status of vocational activity;
2. Status of IWRP development (including explanation if IWRP has not been completed within 90 days);

[17] M.G.L. c.152, §1(12).

3. If client is retraining, copy of grades received from each marking period and other supportive data (such as attendance);
4. Summary of all vocational testing used to help develop an employment goal and a vocational goal; and
5. The name of the OEVR Rehabilitation Review Officer.

Determination of Suitability

It is the responsibility of OEVR to identify those disabled workers' who may benefit from rehabilitation services. OEVR identifies rehabilitation candidates according to injury type after liability has been established, and through referrals from internal DIA sources (including the Office of Claims Administration and the Division of Dispute Resolution), insurers, certified providers, attorneys, hospitals, doctors, employers and injured employees themselves.[18] Through the use of new technology, such as the automatic scheduling system, OEVR has made significant progress in identifying disabled workers for mandatory meetings early on in the claims process.

Once prospective candidates have been identified, an initial mandatory meeting between the injured worker and the Rehabilitation Review Officer is scheduled for the purpose of determining whether or not an injured worker is suitable for VR services. During this meeting, the RRO obtains basic case information from the client, explains the VR process (including suitability, employment objectives in order of priority, client rights, and OEVR's role in the process) and answers any questions the client may have. The failure of an employee to attend the mandatory meeting may result in the discontinuance of benefits until the employee complies.

Once a "mandatory meeting" has concluded, it is the duty of the RRO to issue a decision on the appropriateness of the client for vocational rehabilitation services. This is done through a Determination of Suitability (DOS) Form. Suitability is determined by a number of factors including: medical stability, substantial functional limitations, feasibility and cost-effectiveness of services, and liability must be established. If a client is deemed "suitable," the RRO will write to the insurer and request VR services for the injured worker. The insurer must then choose any OEVR-approved provider so that an Individual Written Rehabilitation Program (IWRP) can be developed. The insurer must also submit to OEVR any pertinent medical records within 10 days. If a client is deemed "unsuitable," the insurer can refer the client again after six months has elapsed.

At any point during the OEVR process after an injured worker has been found suitable for VR services, a RRO can schedule a "team meeting" to resolve issues of disagreement among any of the represented parties. All parties are invited and encouraged to attend team meetings. At the conclusion of the meeting, if parties are still in disagreement, the RRO can refer the matter back to the parties with recommendations and an action plan. All team meetings are summarized in writing.

[18] M.G.L. c.152, §30 (E-H); 452 C.M.R. §4.00

Individual Written Rehabilitation Program (IWRP)

After an employment goal and vocational goal has been established for the injured worker, an Individual Written Rehabilitation Program (IWRP) can be written. The IWRP is written by the vocational provider and includes the client's vocational goal, the services the client will receive to obtain that goal, an explanation why the specific goal and services were selected, and the signatures necessary to implement it. A vocational rehabilitation program funded voluntarily by the insurer has no limit of length, however OEVR-mandated IWRP's are limited to 52 calendar weeks for pre-12/23/91 injuries and 104 calendar weeks for post-12/23/91 injuries.[19] The IWRP should follow OEVR's priority of employment goals:

1. Return to work with same employer, same job modified;
2. Return to work with same employer, different job;
3. Return to work with different employer, similar job;
4. Return to work with different employer, different job;
5. Retraining; and
6. Any recommendation for a workplace accommodation or a mechanical appliance to support the employee's return to work.

In order for an IWRP to be successful, it needs to be developed jointly with the client and the employer. An IWRP with the specific employment goal of permanent, modified work must include:

1. a complete job description of the modified position (including the physical requirements of the position);
2. a letter from the employer that the job is being offered on a permanently modified basis; and
3. a statement that the client's treating physician has had the opportunity to review and comment on the job description for the proposed modified job.

Before any vocational rehabilitation activity begins, the IWRP must be approved by OEVR. Vocational Rehabilitation is successful when the injured worker completes a VR program and is employed for 60 days. A "Closure Form" must then be signed by the provider and sent to the appropriate RRO. Closures should meet the following criteria:

1. all parties should understand the reasons for case closure;
2. the client is told of the possible impact on future VR rights;
3. the case is discussed with the RRO;
4. a complete closure form is submitted by the provider to OEVR; and
5. the form should contain new job title, DOT code, employer name and address, client wage, and the other required information if successfully rehabilitated.

[19] M.G.L. c.152, §19.

Lump Sum Settlements

An employee obtaining vocational rehabilitation services must seek the consent of OEVR before a lump sum settlement can be approved. In the past, disabled and unemployed workers have settled for lump sum payments without receiving adequate job training or education on how to find employment. Settlement money would run out quickly and employees would be left with no means of finding suitable work. OEVR tries to have disabled employees initiate, if not complete, rehabilitation before the lump sum settlement is approved. Nevertheless, OEVR will consent to a lump sum settlement if the insurer agrees to continue to provide rehabilitation benefits.

Utilization of Vocational Rehabilitation

In fiscal year 2004, OEVR was headed by a Director and staffed by 10 Rehabilitation Review Officers, 1 Disability Analyst, and 5 Clerks. Out of the 2,304 cases referred to OEVR in FY'04, 85% proceeded to a "mandatory meeting" for a determination of suitability for vocational rehabilitation services. The remaining 15% exited the system for reasons that include the non-establishment of liability or that the employee was not on compensation. Of those cases which received a "mandatory meeting," 38% were referred to the insurer/self-insurer with a request to initiate vocational rehabilitation services by an OEVR certified provider. In FY'04, there was a 43% success ratio of injured workers who completed plans and returned to work.

Table 19: Utilization of Voc. Rehab. Services, FY'01 - FY'04

Fiscal Year	*Referrals to OEVR*	*Mandatory/ Inform. Meetings*	*Referrals to Insurer for VR*	*IWRPs approved*	*Return to work*	*% RTW after plan development*
FY'04	**2,304**	**1,964/44**	**746**	**474**	**203**	**43%**
FY'03	2,494	2,287/43	886	507	187	37%
FY'02	2,743	2,348/23	842	501	214	43%
FY'01	2,895	2,421/132	915	483	253	52%

Source: DIA - OEVR

Trust Fund Payment of Vocational Rehabilitation

If an insurer refuses to pay for vocational rehabilitation services while OEVR determines that the employee is suitable for services, the office may utilize monies from the Trust Fund to finance the rehabilitation services. In fiscal year 2004, $40,070 was paid for rehabilitation services and the DIA collected $39,322 from insurers. OEVR is required to seek reimbursement from the insurer when the Trust Fund pays for the rehabilitation and the services are deemed successful (e.g., the employee returns to work). The DIA may assess the insurer a minimum of two times the cost of the services.

OEVR Advisory Group

In July of 2004, the Office of Education and Vocational Rehabilitation resumed an Advisory Group to enhance the working relationship between OEVR and the provider community. The Advisory Group consist of five members from the provider community, one member from the OEVR RRO staff and the Director of OEVR. Meetings are held on a quarterly basis to allow the parties to discuss procedural, regulatory and statutory changes that could benefit the vocational rehabilitation system.

Advisory Council Subcommittee on OEVR Issues

For the past four years the Advisory Council's subcommittee on OEVR issues has worked conjointly with the DIA administration and the Director of OEVR in an effort to identify and rectify concerns within the vocational rehabilitation system.

As a result of the subcommittee's recommendations, a working dialogue has been initiated between OEVR and the Department of Labor & Workforce Development to integrate career centers into the vocational rehabilitation process. Furthermore, referrals are reaching OEVR in a more timely fashion with the recent completion of the Oracle conversion project.

In 2005, the Advisory Council will address OEVR issues and identify areas within the vocational rehabilitation system that can be improved upon. The Advisory Council plans to forward all future recommendations to the attention of the OEVR Advisory Group.

OFFICE OF SAFETY

The Office of Safety is responsible for establishing and supervising the Safety Grant Program for the education and training of employees and employers in the recognition, avoidance and prevention of unsafe or unhealthy working conditions. Each year the safety and training grants are awarded to qualified applicants based upon a competitive selection process initiated by a Request for Response (RFR). The Office of Safety also advises employees and employers of safety issues surrounding the work environment.

Since 1991, the Office of Safety has annually issued its RFR for the "Occupational Safety and Health Education and Training Program." To date, the DIA has funded a total of 557 preventive training programs, which have trained nearly 225,000 workers in the Commonwealth.

The Safety Grant Program

Each fiscal year the DIA's Office of Safety awards $800,000 in safety grants to pay for programs which provide workplace safety training for employees and/or employers of industries operating within the Commonwealth and whose entire staff is covered under the Massachusetts Workers' Compensation Law (M.G.L. c.152).

The overall objective of the education and training programs is to reduce work related injuries and illnesses by:

- Identifying, evaluating, and controlling safety and health hazards in the workplace;
- Fostering activities by employees/employers to prevent workplace accidents;
- Making employees/employers aware of all federal and state health and safety standards, statutes, rules and regulations that apply, including those that mandate training and education in the workplace;
- Referring employees/employers to the appropriate agency for abatement procedures for safety and health related issues;
- Targeting preventive educational programs for specifically identified audiences with significant occupational health and/or safety problems;
- Encouraging awareness and compliance with federal and/or state occupational safety and health standards and regulations;
- Promoting understanding among employee and employer groups on the importance of ongoing safety health education and training programs and help to begin such efforts;
- Encouraging labor/management cooperation in the area of occupational safety and health; and
- Encouraging collaborations between various groups, organizations, educational or health institutions to devise innovative, preventive methods for addressing occupational health and safety issues.

Requests for Responses

Each fiscal year the Office of Safety publishes an RFR to notify the general public that safety grants are available. The program has an annual budget of $800,000. In FY'04, proposals could be submitted up to a maximum of $30,000. During the fiscal year, 972 announcement letters were mailed to various industries throughout the state. As a result of these announcement letters and the advertisements published in the regional newspapers, the Office of Safety issued over 172 RFR's in fiscal year 2004. Of the 172 RFR's issued, the DIA received 48 requests for funding (proposals). Of these, approximately 69% received funding.

A uniform criteria to competitively evaluate all proposals received is developed by a Proposal Selection Committee, appointed by the Commissioner. The Committee recommends a list of qualified applicants for funding. Upon approval of this list by the Commissioner, contracts are awarded. In FY'04, the Office of Safety was able to fund a total of 34 grants which resulted in the training of 9,000 employees (see Appendix L for a list of proposals recommended for funding in FY'05). During the fiscal year, over 94% of the participants rated the program they attended as "excellent" or "good."

Changes to the RFR Process

During fiscal year 2004, the Office of Safety examined the Safety Grant Program in an effort to simplify the application process and to expand the number of employees who could benefit from the program. After reviewing the application process, it was discovered that RFR was redundant and that a large amount of money was being spent on administrative costs. To address these issues, the Office of Safety significantly revised the RFR and contacted all of the 2005 applicants to notify them that administrative costs would not be funded without justification. The Office of Safety believes that these changes to the RFR process will help expand the number of grants that can be awarded, thereby, increasing the number of employees who will benefit from the training.

Frank S. Janas Training Center

In October of 2000, the DIA dedicated a new safety training center in memory of the late Frank Janas at the Lawrence Regional Office. Mr. Janas was a beloved DIA employee who worked in the Office of Insurance for seven years. The training center is a valuable tool for both private employers and government agencies that would like to conduct safety-related training or seminars. The conference training center holds 90 auditorium style seats, has valuable conference amenities (wide-screen TV/VCR, Apollo projector, podium, computer hookups, etc.), and is handicap accessible. In fiscal year 2004, the Office of Safety began the process of cataloging all of the safety videos contained in the Frank Janas Training Center. The Office of Safety plans to establish an online library of safety videos to increase there accessibility to the public.

Frank Janas Training Center Contact:
Dan DeMille
Division of Industrial Accidents
160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420
email: Dand@dia.state.ma.us

OFFICE OF INSURANCE

The Office of Insurance issues self insurance licenses, monitors all self insured employers, maintains the insurer register, and monitors insurer complaints.

Self Insurance

A license to self insure is available for qualified employers with at least 300 employees and $750,000 in annual standard premium.[20] To be self insured, employers must have enough capital to cover the expenses associated with self insurance. However, many smaller and medium-sized companies have also been approved to self insure. The Office of Insurance evaluates employers every year to determine their eligibility for self insurance and to establish new bond amounts.

For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover any losses that may occur.[21] The amount varies for every company depending on their previous reported losses and predicted future losses. The average bond is usually over $1 million and depends on many factors including loss experience, the financial state of the company, the hazard of the occupation, the number of years as a self insured, and the attaching point for re-insurance.

Employers who are self insured must purchase reinsurance of at least $500,000. The per case deductible of the reinsurance varies from $100,000, a relatively modest amount, to much higher amounts. Smaller self insured companies may also purchase aggregate excess insurance to cover multiple claims that exceed a set amount. Many self insured employers engage the services of a law firm or a third party administrator (TPA) to handle claims administration.

In FY'04, one new license was issued to bring the total number of "parent-licensed" companies to 129, covering a total of 380 subsidiaries. Each self insurance license provides approval for a parent company and its subsidiaries to self insure. This amounts to approximately $245 million in equivalent premium dollars.

Four semi-autonomous public employers are also licensed to self insure including the Massachusetts Bay Transportation Authority (MBTA), the Massachusetts Turnpike Authority (MTA), the Massachusetts Port Authority, and the Massachusetts Water Resource Authority (MWRA).[22]

[20] C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers. These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover for all incurred losses.

[21] M.G.L. 452 C.M.R. 5:00.

[22] The Commonwealth of Massachusetts does not fall under the category of self insurance, although its situation is analogous to self insured employers. It is not required to have a license to self insure because of its special status as a public employer and it therefore funds workers' compensation claims directly from the treasury as a budgetary expense. The agency responsible for claims management, the Public Employee Retirement Administration, has similar responsibilities to an insurer, however, the state does not pay insurance premiums or post a bond for its liabilities (M.G.L. c.152, §25B).

Insurance Unit

The Insurance Unit maintains a record of the workers' compensation insurer for every employer in the state. This record, known as the insurer register, dates back to the 1920's and facilitates the filing and investigation of claims after many years.

In the past, the insurance register had a record keeping system, which consisted of information manually recorded on 3x5 notecards (a time consuming and inefficient method for storing files and researching insurers). Every time an employer made a policy change, the insurer mailed in a form and the notecard was changed manually.

Through legislative action, the Workers' Compensation Rating and Inspection Bureau (WCRIBM) became the official repository of insurance policy coverage in 1991. The DIA was provided with computer access to this database, which includes policy information for the eight most current years. The remainder of policy information must be researched through the files at the DIA, now stored on microfilm. In FY'04, an estimated 4,927 inquiries were made to the Insurance Register.

The Insurance Unit is also responsible for handling insurance complaints. Complaints are often registered by telephone and the unit will provide the party with the necessary information to handle the case.

OFFICE OF INVESTIGATIONS

In Massachusetts, employers with one or more employees are required to have a valid workers' compensation policy at all times. Employers can meet this statutory requirement by purchasing a commercial insurance policy, gaining membership in a self insurance group, or licensing as a self insurer (M.G.L. c.152, §25A). The Office of Investigations is charged with enforcing this mandate by investigating whether employers are maintaining insurance policies and by imposing penalties when violations are uncovered. When an employer fails to carry an insurance policy and an injury occurs at their workplace, the claim is paid from the DIA's Workers' Compensation Trust Fund (funded entirely by the employers who purchase workers' compensation policies). In fiscal year 2004, the Office of Investigations had twelve investigators on staff.

Referrals to the Office of Investigations

The Office of Investigations has access to the Workers' Compensation Rating and Inspection Bureau (WCRIBM) database on all policies written by commercial carriers in the state. From this database, it can be determined which employers have either canceled or failed to renew their insurance policies. Employers on this database are investigated for insurance coverage or alternative forms of financing (self-insurance, self-insurance group, reciprocal exchange).

The Office of Investigations also works with other state agencies for referrals. Both the Division of Employment & Training and the Secretary of State's Office have been utilized in the past.

Another type of referral the Office of Investigations utilizes is through anonymous calls and letters received from the general public. These tips have historically played a crucial role in identifying which companies may be without insurance.

Referrals can also come to the Office of Investigations internally within the DIA. Whenever a Section 65 claim (an injury occurs at an uninsured business) is entered into the system, the Office of Investigations will be notified by the Office of Insurance that a particular company is without insurance.

The Initial "In-House" Investigation

Referrals received by the Office of Investigations are assigned to an individual investigator who conducts comprehensive "in-house" research utilizing all available databases. This initial research allows the investigator to close cases where an insurance policy has been discovered or when there is substantial evidence that a company has ceased operations. Once a referral has been thoroughly investigated "in-house" and it is demonstrated that a business is violating the statute, the DIA will issue a compliance letter requesting they provide proof of workers' compensation insurance. If the business fails to respond to this letter or is unable to display proof of coverage, the investigator will make an "on-site" visit to the worksite.

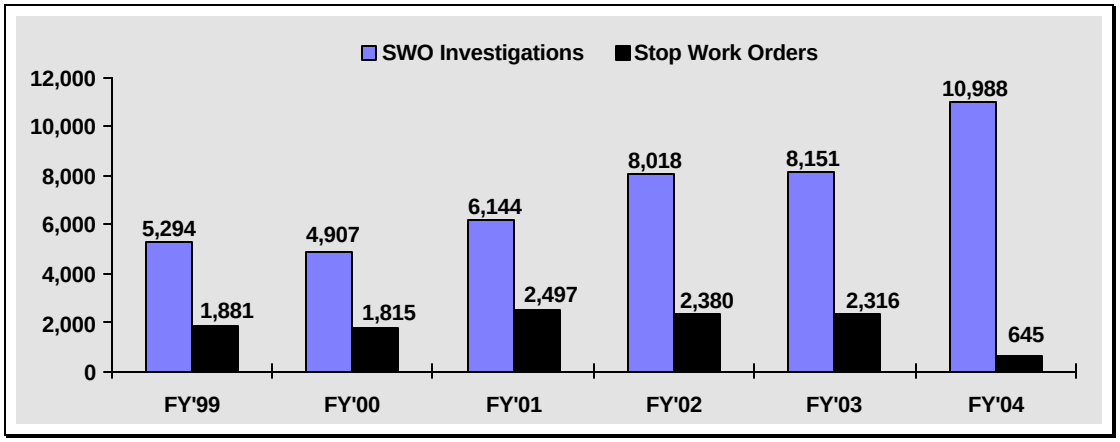
"On-Site" Investigations - Stop Work Orders

During an "on-site" visit to a worksite, an investigator will request that the business provide proof of workers' compensation coverage. If a business fails to provide proof of coverage, a "stop work order" (SWO) is immediately issued. Such an order requires that all business operations cease and the SWO becomes effective immediately upon service. However, if an employer chooses to appeal the stop work order, they have the right to remain open until the case is resolved.

Fines resulting from a stop work order begin at $100 per day, starting the day the stop work order is issued, and continuing until proof of coverage and payment of the fine is received by the DIA. An employer who believes the issuance of the stop work order was unwarranted has ten days to file an appeal. A hearing must take place within 14 days, during which time the stop work order will not be in effect. The stop work order and penalty will be rescinded if the employer can prove it had workers' compensation insurance during the disputed time. If at the conclusion of the hearing the DIA finds the employer had not obtained adequate insurance coverage, the employer must pay a fine of $250 a day. Any employee affected by a stop work order must be paid for the first ten days lost and that period shall be considered "time worked."

In addition to established fines, an employer lacking insurance coverage may be subject to a criminal court proceeding with a possible fine not to exceed $1,500, or by imprisonment for up to one year, or both. If the employer continues to fail to provide insurance, additional fines and imprisonment may be imposed. The Commissioner or designee can file criminal complaints against employers (including the president and treasurer of a corporation) that violate any aspect of Section 25C.

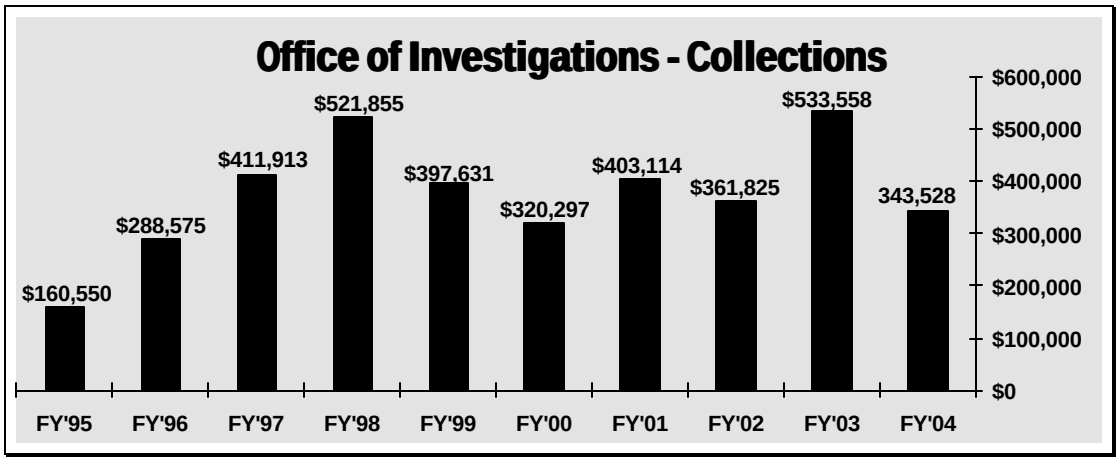
Figure 15: MA SWO's & Investigations



Source: Office of Investigations

In fiscal year 2004, 645 stop work orders were issued as a result of 10,988 investigations conducted. Of the 645 stop work orders issued, 633 (98%) were issued to "small" companies (1-10 employees), 12 were issued to "medium" companies (11-75 employees) and none were issued to "large" companies (76+ employees).

Figure 16: Office of Investigations - Collections



Source: Office of Investigations

In fiscal year 2004, the Office of Investigations collected $343,528 in fines from employers who violated the workers' compensation insurance mandate. The DIA has explained on numerous occasions that there will be an initial drop in both the number of stop work orders issued and the amount of collections received as the new revisions to the enforcement and compliance system take effect.

Public Awareness Campaign

In fiscal year 2004, the Office of Investigations developed a bilingual statewide public awareness campaign aimed at educating employers in the Commonwealth of the mandatory requirement to provide workers' compensation insurance. The campaign, titled "Putting Workers First," utilized paid and free media, television and radio public service announcements, and various forms of print media. In conjunction with the campaign, the DIA established a toll-free number (1-877-MASSAFE) to further educate employers and employees on their rights and responsibilities and to allow for the reporting of suspected employers who are violating the law.

Television personality, Bob Vila, was the official spokesperson for the Public Service Announcements.[23] The campaign was designed to coincide with seasonal businesses (landscapers, painters, roofers, and domestic help) since they have historically had a high-risk for injuries. The intent of the campaign is to reduce the number of claims against the Trust Fund, resulting in reduced assessments to employers.

[23] Bob Vila is the television creator of "This Old House" and "Home Again." Mr. Vila donated his services to the Department of Industrial Accidents

WORKERS' COMPENSATION TRUST FUND

Section 65 of the Workers' Compensation Act establishes a Trust Fund in the State Treasury to make payments to injured employees whose employers did not obtain insurance, and to reimburse insurers for certain payments under Sections 26, 34B, 35C, 37, 37A, and 30H. The DIA has established a department known as the Workers' Compensation Trust Fund (WCTF) to process requests for benefits, administer claims, and respond to claims filed before the Division of Dispute Resolution.

Uninsured Employers

Section 65 of the Workers' Compensation Act directs the Trust Fund to pay benefits resulting from approved claims against Massachusetts' employers who are uninsured in violation of the law. The Trust Fund must either accept the claim or proceed to Dispute Resolution over the matter. Every claim against the fund under this provision must be accompanied by a written certification from the DIA's Office of Insurance, stating that the employer was not covered by a workers' compensation insurance policy on the date of the alleged injury, according to the Division's records.[24] In FY'04, $4,375,208 was paid to uninsured claimants, 213 claims were filed, and 194 claims for benefits were paid.

Second Injury Fund Claims (Sections 37, 37A, and 26)

In an effort to encourage employers to hire previously injured workers, the Legislature established a Second Injury Fund to offset any financial disincentives associated with the employment of injured workers.

Section 37 requires insurers to pay benefits at the current rate of compensation to all claimants, whether or not their injury was exacerbated by a prior injury. When the injury is determined to be a "second injury," insurers become eligible to receive reimbursement from the DIA's WCTF for up to 75% of compensation paid after the first 104 weeks of payment. [25] Employers are entitled to an adjustment to their experience modification factors as a result of these reimbursements.

Section 37A was enacted to encourage the employment of servicemen returning from World War II. The Legislature created a fund to reimburse insurers for benefits paid for an injury aggravated or prolonged by a military injury. Insurers are entitled to reimbursement for up to fifty percent of the payments for the first 104 weeks of compensation and up to one hundred percent for any amount thereafter.

Section 26 provides for the direct payment of benefits to workers injured by the activities of fellow workers, where those activities are traceable solely and directly to a physical or

[24] 452 C.M.R. 3.00

[25] An employee is considered to suffer a second injury when an on the job accident or illness occurs that exacerbates a pre-existing disability. How the preexisting condition was incurred is immaterial; the impairment may derive from any previous accident, disease, or congenital condition. The disability, however, must be "substantially greater" due to the combined effects of the preexisting impairment and the subsequent injury than the disability as a result of the subsequent injury by itself.

mental condition, resulting from the service of that fellow employee in the armed forces. (A negligible number of these claims have been filed.)

At the close of fiscal year 2004, 365 §37 claims were paid and settled. The total amount paid in settlements in FY'04 was $19,739,158.

Vocational Rehabilitation (Section 30H)

Section 30H provides that if an insurer and an employee fail to agree on a vocational rehabilitation program, the Office of Education and Vocational Rehabilitation (OEVR) must determine if vocational rehabilitation is necessary and feasible to return the employee to suitable employment. If OEVR determines that vocational rehabilitation is necessary and feasible, it will develop a rehabilitation program for the employee for a maximum of 104 weeks. If the insurer refuses to provide the program to the employee, the cost of the program will be paid out of the Section 65 Trust Funds. If upon completion of the program OEVR determines that the program was successful, it will assess the insurer no less than twice the cost incurred by the office, with that assessment paid into the Trust Fund. In FY'04, $40,070 was paid for rehabilitation services and the DIA collected $39,322 from insurers. During FY'04, 14 claims for benefits were filed and 19 claims for benefits were paid out.

Latency Claims (Section 35C)

Section 35C states that when there is at least a five year difference between the date of injury and the date of benefit eligibility (for Section's 31, 34, 35A or 35), benefits' paid will be based upon levels in effect on the date of eligibility. This same date of eligibility rather than the date of injury is also used to compute supplemental benefits known as COLA (Cost of Living Adjustments) for employees subject to this Section. In FY'04, approximately $899,231 was paid as latency claims.

Cost of Living Adjustments (Section 34B)

Section 34B provides supplemental benefits for persons receiving death benefits under Section 31 and permanent and total incapacity benefits under Section 34A, whose date of personal injury was at least 24 months prior to the review date. The supplemental benefit is the difference between the claimant's current benefits and his/her benefit after an adjustment for the change in the statewide average weekly wage between the review date and the date of injury. Insurers pay the supplemental benefit concurrently with the base benefit. They are then entitled to quarterly reimbursements for the supplemental benefits paid on all claims with dates of injury occurring prior to October 1, 1986. For injury dates after October 1, 1986, insurers will be reimbursed for any increase that exceeds 5%. COLA payments for FY'04 totaled $1,111,415 for the Public Trust Fund and $18,110,377 for the Private Fund.

OFFICE OF HEALTH POLICY

The Office of Health Policy (OHP) was created in July of 1993 by the Commissioner pursuant to the promulgation of M.G.L. c.152, §5, §13, and §30. The statute authorizes the Office of Health Policy to approve and monitor workers' compensation utilization review (UR) programs in the Commonwealth to ensure compliance with the requirements of 452 CMR 6.00 et seq.

During fiscal year 2004, the Office of Health Policy was staffed by five employees: an Executive Director (Registered Nurse), a UR Coordinator (Registered Nurse), a Clinical Coordinator (Registered Nurse), and two Program Analysts.

Utilization Review

Utilization review is a system for reviewing the "appropriate and efficient allocation of health care services" to determine whether those services should be paid or provided by an insurer. This review of medical care is conducted before, during, or following treatment to an injured worker. The utilization review and quality assessment regulations mandate that all insurers conduct UR on all health care services provided to injured workers that have been delivered on or after October 1, 1993, regardless of the date the employee is injured. UR agents must use the treatment guidelines endorsed by the Health Care Services Board and adopted by the DIA for the specific conditions to which these guidelines apply. All medical care relating to workplace injuries must be reviewed under established guidelines and review criteria.

In Massachusetts, UR agents are required to use licensed health care professionals to conduct utilization review. Care and treatment can be approved by a licensed or registered nurse using established guidelines and review criteria. Care that cannot be approved must be reviewed by a licensed health care practitioner in the same school as the provider prescribing the care or treatment for the injured employee. All decisions regarding care and treatment (and the basis for the decision) must be disclosed in writing to the injured employee and the ordering practitioner within specific timeframes. Any decision, by any licensed reviewer cannot be arbitrary and will be based on established guidelines. For care that cannot be approved, the UR agent must inform the injured employee and the ordering practitioner of their rights and procedure to appeal the decision to the UR agent. After the exhaustion of this process, the injured worker and practitioner have additional rights to appeal the determination of the UR agent to the DIA or file a claim for payment to the DIA in accordance with 452 CMR 1.07.

The OHP conducts investigations on all complaints received. Violations are recorded and forwarded to the Commissioner for due process. The OHP tracks the nature and pattern of these complaints and takes this information into account when reviewing policy and procedures of UR agents.

To ensure the regulatory compliance with UR regulations, the OHP:

- Reviews new applications from UR agents seeking approval to conduct UR for workers' compensation in Massachusetts. The OHP UR Coordinator provides consultation as requested throughout the application process to ensure all systems, policies and procedures comply with the DIA's rules, regulations and standards.
- Conducts system wide Quality Assessment Audits annually from UR agents. The OHP UR Coordinator supports and assists the UR agent throughout the following alternating process to remain in compliance with the DIA's regulations and requirements:

  Application Review - Conducted every two years, the Application Review examines demographic information, changes in operations, and policy procedures.

  Medical Record Review Audits - A sample of the agent's medical records are reviewed to monitor the quality of care provided to injured workers and to ensure the agent's compliance with the DIA's rules and regulations.

  On-Site Reviews - Upon a mutually agreed date, this review is conducted for the purpose of confirming that the organization is operating in a manner consistent with 452 CMR 6.0 *et seq*.
- Audits the applications of Preferred Provider Arrangements and processes them according to 452 CMR 6.03.

Outreach and Support to UR Agents

The OHP provides outreach and support to UR agents in an effort to assist them in offering the highest quality of service to injured workers. Each year, the OHP hosts a meeting with UR agents to provide updates on common issues and to share new information. Agents are encouraged to contribute input for agenda items. As necessary, the agency's UR Coordinator will schedule meetings and phone consultations with any UR agent having difficulty complying with the DIA's regulations. The OHP also provides in-service training to employees of UR agents upon request.

Health Care Services Board

Pursuant to M.G.L. c.152 §13, the Health Care Services Board ("HCSB") is a medical advisory body of 14 members specified by statute and appointed by the Commissioner. The HCSB met throughout fiscal year 2004, discharged its statutory responsibilities with regularity, and continued to assist the Commissioner and the DIA with the implementation of multiple medical initiatives stemming from the Workers' Compensation Reform at of 1991.

During fiscal year 2004, two members left the HCSB and two members were appointed. The HCSB managed its affairs with its Chair appointed by the Commissioner, Legal Counsel and administrative staff.

Complaints Against Providers - The HCSB is required to accept and investigate complaints from employees, employers and insurers regarding the provision of health

care services. Such complaints include provider's discrimination against compensation claimants, over-utilization of procedures, unnecessary surgery or other procedures, and inappropriate treatment of workers' compensation patients. Upon a finding of a pattern of abuse by a particular provider, the HCSB is required to refer its findings to the appropriate board of registration. The HCSB continues to receive, investigate and resolve complaints against health care practitioners providing medical services to injured workers under the workers' compensation statute. In fiscal year 2004, the HCSB received 3 such complaints.

IME Roster Criteria - The HCSB is also required to develop eligibility criteria to select and maintain a roster of qualified impartial physicians to conduct medical examinations pursuant to M.G.L. c.152, §8(4) and §11A. The HCSB continued to work with the Senior Judge in the recruitment of physicians and health care practitioners throughout fiscal year 2004.

Treatment Guidelines - Under §13 of c.152, the Commissioner is required to ensure that adequate and necessary health care services are provided to injured workers by utilizing treatment guidelines developed by the HCSB, including appropriate parameters for treating injured workers. In addition to an annual review and endorsement of the existing 28 medical treatment guidelines adopted by the DIA, the HCSB endorsed two treatment guidelines that had been amended. Also, the HCSB continues to work on medical guidelines for pain management while reviewing its existing guidelines.

Compensation Review System (CRS)

As part of the 1991 Workers' Compensation Reform Act, the statute mandated that the DIA "monitor the medical and surgical treatment provided to injured employees and the services of other health care providers, and monitor hospital utilization as it relates to the treatment of injured employees. The monitoring shall include determinations concerning the appropriateness of the service, whether treatment is necessary and effective, the proper costs of services, and the quality of treatment" (M.G.L. c.152, §13).

In order to fulfill this legislative mandate, the OHP set out to create a Compensation Review System (CRS). The goals of CRS are to provide standardized, comparable data for the improvement of programs, policies, and services relative to injured workers in Massachusetts, as well as review compliance with HCSB Treatment Guidelines, review patterns of care, and review utilization of medical services and trends in medical care. In addition, CRS will aid in controlling costs by detecting over-utilization and improper utilization of treatments. This will be accomplished by collecting data from insurers, self-insurers and third party administrators (TPA) and comparing this data to the treatment guidelines. During 2004, the OHP focused on claims related to Treatment Guidelines #20 & #21 for back injuries. In 2005, data collection will continue to be related to back injuries and include Treatment Guideline #26 for Neuromusculo-Skeletal Injury and Treatment Guideline #27 for Chronic Pain Syndrome.

In 2004, the OHP collected and compiled data from insurers, self-insurers and third party administrators (TPAs) from across the state. The OHP recorded a 98% compliance rate from these entities. During the year, the OHP held meetings with insurers, self-insurers, TPAs, the Health Care Services Board and Advisory Council to update them on the

progress of CRS. At these meetings, the OHP discussed the project's status, data issues, compliance with Massachusetts HCSB Treatment Guidelines and preliminary claims analysis related to the access of health care, length of treatment, and services provided to injured workers. An analysis of CRS data has highlighted billing issues, utilization review issues and trends in treatment.

Currently, the OHP is merging additional data collected into the database for review. The OHP will continue to use the data to evaluate injured workers' access to medical care, standards of practice and compliance with the Massachusetts HCSB Treatment Guidelines, over and under-utilization of treatments, trends in the treatment of injured workers with back injuries and the need to update and revise the Massachusetts HCSB Treatment Guidelines. CRS will continue to monitor treatment guidelines and evaluate medical care received by injured workers.

DIA REGIONAL OFFICES

The Division of Industrial Accidents has offices in Boston, Lawrence, Worcester, Fall River, and Springfield. The main headquarters are located in Boston where all DIA case records are stored.

The Senior Judge and the managers of the conciliation and vocational rehabilitation units are located in Boston, but each has managerial responsibility for the operations of their respective Divisions at the regional offices.

Each regional office has a regional manager, a staff of conciliators, stenographers, vocational rehabilitation counselors, disability managers, administrative secretaries, clerks, and data processing operators. In addition, Administrative Judges make a particular office the base of their operations, with an assigned administrative secretary.

Administration and Management of the Offices

Each regional manager is responsible for the administration of his or her regional office. The offices are equipped with conference rooms and hearings rooms in which conciliations, conferences, hearings and other meetings are held. A principle clerk and a data processing operator manage the scheduling of these proceedings and the assignment of meeting rooms through the Oracle case scheduling system.

Cases are assigned to Administrative Judges by the Oracle system in coordination with the Senior Judge. Conciliators are assigned cases according to availability on the day of the meeting, and report to the conciliation manager located at the Boston office. Likewise, stenographers are assigned when needed, but report to the stenographer manager at the Boston office. The vocational rehabilitation personnel report directly to the OEVR manager in the Boston office, and take assignments as delegated from Boston.

When an employee or insurer files a workers' compensation claim or complaint with the DIA, the case is assigned to the office geographically closest to the home of the claimant. Assignments are based on zip codes, with each regional office accounting for a fixed set of zip codes.

Each regional office occupies space rented from a private realtor. The manager is responsible for working with building management to ensure the building is accessible and that the terms of the lease are met. Moreover, each regional manager is responsible for maintenance of utilities, including the payment of telephone, electricity, and other monthly services. Therefore, the costs of operating each office is managed by each regional manager.

Resources of the Offices

Each of the regional offices has moved to expanded and enhanced office space within the last six years.

Court rooms have been updated and modernized according to the needs of each regional office, including handicap accessibility and security systems. Moreover, each regional office is equipped with video equipment to assist with the presentation of court room evidence.

Each office has been provided with personal computers networked to the Boston office and with a CD-ROM for access to software on the MA General Laws, MA court reporters, and DIA reports.

The following are addresses for the regional offices:

Fall River
30 Third Street
Fall River, MA 02720
(508) 676-3406
Henry Mastey, Manager

Lawrence
160 Winthrop Avenue
Lawrence, MA 01840
(978) 683-6420
Dan DeMille, Manager

Springfield
436 Dwight Street, Room 105
Springfield, MA 01103
(413) 784-1133
Marc Joyce, Manager

Worcester
340 Main Street
Worcester, MA 01609
(508) 753-2072
Jonathan Ruda, Manager

SECTION
- 5 -
DIA FUNDING

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DIA FUNDING

To ensure that the Division of Industrial Accidents has adequate funds, the Legislature required the employers of Massachusetts, both public and private, to pay assessments covering the expenses of operating the agency and for the payment of trust fund benefits. In addition to these assessments, the DIA also derives revenue from the collection of fees (for various filing costs) and fines (for violations of the Act). There are no tax dollars used to fund the Division of Industrial Accidents or any of its activities.

Table 20: Funding Mechanisms for the Division of Industrial Accidents

Assessments - A charge levied against all companies in Massachusetts on their workers' compensation policy;
Referral Fees - A fee paid by the insurer when a case cannot be resolved at the Conciliation level and is referred to Dispute Resolution for adjudication. The current referral fee is $597.21 as of October 1, 2004. This fee is 65% of the current State Average Weekly Wage (SAWW), which is $918.78. (This figure changes every October 1st);
Fines - There are three types of fines. First, a Stop Work Order Fine is issued to a company without workers' compensation insurance, and it accumulates until they obtain a policy and the fine is paid. Second, a Late First Report Fine is issued to a company if the injury is not reported within the specified time. This amount is $100. Third, a 5% fine is charged when assessments are paid later than 30 days of billing.

Source: Division of Industrial Accidents' Website: www.mass.gov/dia/

Each year, the DIA must determine an assessment rate that will yield revenues sufficient to pay the obligations of the Workers' Compensation Trust Fund and the operating costs for the DIA. This assessment rate, multiplied by the employer's standard premium, is the DIA assessment, and is paid as part of an employer's insurance premium.[26] The assessment rate for private sector employers in FY'05 is 4.913% of standard premium. This represents a 34% increase from the FY'04 rate of 3.670%.

The Special Fund - The DIA's operating expenses are paid from a Special Fund, funded entirely by assessments charged to private sector employers. Operating expenses must be appropriated by the Legislature each year through the General Appropriations Act. The DIA reimburses the General Fund the full amount of its budget appropriations plus fringe benefits and indirect costs from the assessments, fines, and fees collected. Payments are made quarterly. Chapter 23E of the Massachusetts General Laws directs the Advisory Council to review the DIA's operating budget as well as the Workers' Compensation Trust Fund budgets. With the affirmative vote of seven members, the Council may submit an alternative budget to the Director of Labor and Workforce Development.

The Trust Fund - The Trust Fund was established so the DIA can make payments to uninsured, injured employees and employees denied vocational rehabilitation services by

[26] For employers that are self insured or are members of self insured groups, an "imputed" premium is determined, whereby the WCRB will estimate what their premium would have been had they obtained insurance in the traditional indemnity market. Some employers are entitled to "opt out" from paying a full assessment. By opting out, the employer agrees that it can not seek reimbursement for benefits paid under sections 34B, 35C, 37, 30H, 26, and 37A. Separate opt out assessment rates are determined.

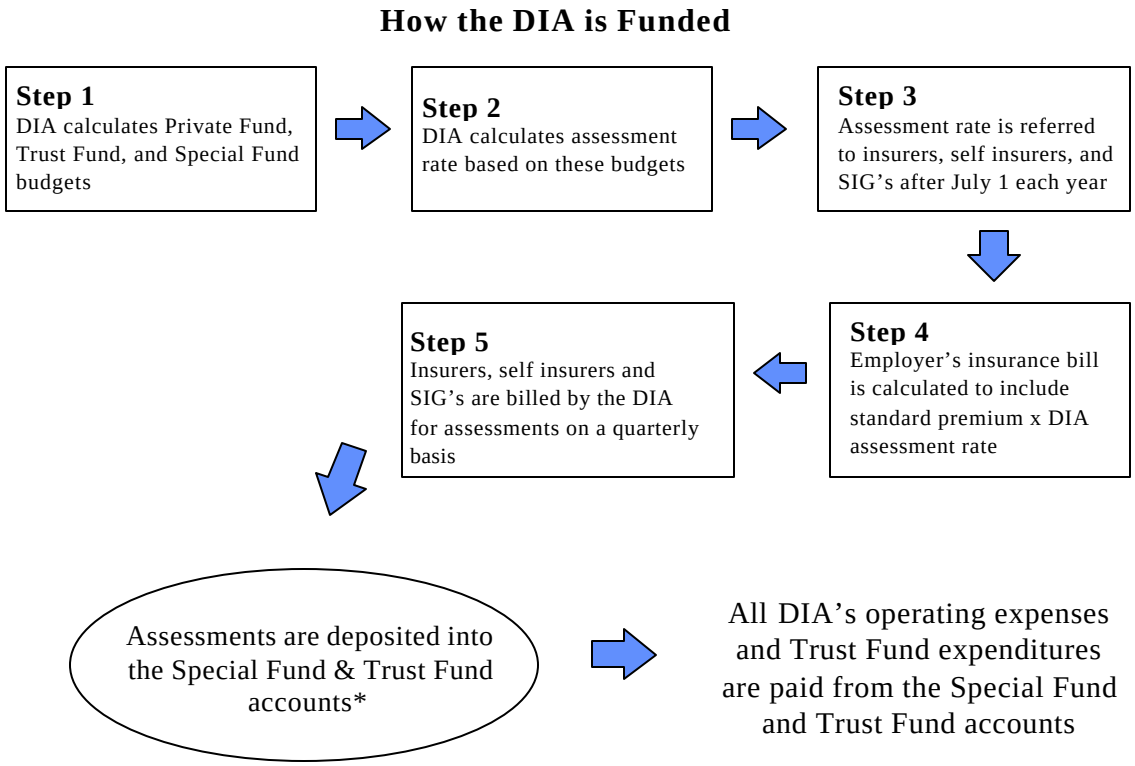
their insurers. In addition, it must reimburse insurers for benefits for second and latent injuries, injuries involving veterans, and for specified cost of living adjustments.[27] These obligations are paid out of the Trust Fund. One account is reserved for payments to private sector employers (the private trust fund); the other is for payments to public sector employers (the public trust fund).

The Funding Process

At the beginning of each fiscal year, the DIA estimates the amount of money needed to maintain its operations in the next fiscal year. This amount is refined by December, when it is submitted to the Governor's office for inclusion in the Governor's budget (House 1), and submitted for legislative action.

In May and June the DIA uses consulting actuaries to estimate future expenses and determine the assessments necessary to fund the special fund and the trust fund. The budgets and the corresponding assessments must be submitted to the Director of Labor and Workforce Development by July 1st annually. By July, the Legislature appropriates the DIA's operating expenses. At that time, insurance carriers are notified of the assessment rates paid quarterly directly to the DIA. Collected assessments are deposited into the DIA's accounts, which are managed by the Commonwealth's Treasurer.

Figure 17: DIA Funding Process

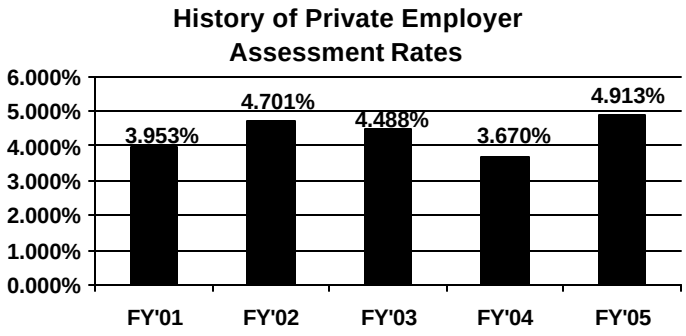


*Note: Maintained by the State Treasurer.

[27] M.G.L. c.152, §65(2).

PRIVATE EMPLOYER ASSESSMENTS

Figure 18: History of Private Employer Assessment Rates



On June 25, 2004, KPMG released an analysis of the DIA's FY'05 assessment rates as mandated under M.G.L. c.152, Section 65. Specifically, the report detailed the estimated amount required by the Special Fund and Trust Funds for FY'05, beginning July 1, 2004. Included in the report are the assessment rates to be applied to public and private employer insurance premiums. The private employer assessment rate has been calculated to be **4.913%** of standard premium, an increase of 34% from last year's assessment (3.670%).

The public employer assessment rate has been calculated to be **35.362%** of standard premium, a decrease of 21% from last year's assessment (45.043%).

Overview of Assessment Rate Calculations

KPMG uses the following six steps in determining the assessment rates for both private and public employers:

1. Project the Fiscal Year 2005 Expenditures;
2. Project the Fiscal Year 2005 Income (excluding assessments);
3. Estimate Fiscal Year 2005 Balance Adjustments;
4. Convert Above Items to Ratios by comparing them to the Assessment Base ('03 Paid Losses);
5. Calculate the Assessment Ratio by Subtracting the Projected Income and Balance Adjustment Ratios from the Projected Expenditure Ratio; and
6. Calculate the Assessment Rate by multiplying the Assessment Ratio by the Assessment Base Factor.

1. FISCAL YEAR 2005 PROJECTED EXPENDITURES: $83.2M

The first step in the assessment process is the calculation of the expected FY'05 expenditures. Private employers are assessed for the sum of the Private Trust Fund budget and the Special Fund budgets.

PRIVATE TRUST FUND BUDGET	Projected FY'05 Expenditures (06/04)
Section 37 (2nd Injuries)	$23,808,600
Uninsured Employers	$ 6,000,000
Section 30H (Rehabilitation)	$ 9,500
Section 35C (Latency)	$ 1,530,000
Section 34B (COLA's)	$24,246,581
Defense of the Fund	$ 4,200,000
Total:	**$59,794,681**

SPECIAL FUND BUDGET	Projected FY'05 Expenditures (06/04)
Total:	**$23,394,072**

PRIV. EMPLOY. EXPENDITURES	Projected FY'05 Expenditures (06/04)
Total:	**$83,188,753**

2. PROJECTED FISCAL YEAR 2005 INCOME: $6.0M

Any income derived by the funds is used to offset assessments. An amount is projected for the collection of fees and fines for deposit in the Special Fund, reimbursements from uninsured employers for deposit in the Private Trust Fund, and an amount estimated for interest earned on the Private Fund and the Special Fund balances.

FY'05 Fines and Fees (Special Fund) = $5,000,000
FY'05 Income Due to Reimbursements = $ 680,000
Estimated Investment Income (FY'04) = $ 311,874 (Private Fund: $101,860/Special Fund: $210,014)

Total Projected FY'04 Income: $5,991,874

3. ADJUSTMENTS TO FUND BUDGETS: $6.2M

According to M.G.L. c.152, §65(4)(c), the amount assessed employers for any fund must be reduced by a certain percentage of moneys held over from the previous year. Any amount greater than 35% of FY'03 expenditures in a particular fund must be used to reduce amounts assessed for that fund in FY'05. The balances of both the Special Fund and Private Trust Fund at the end of FY'04 will have a surplus exceeding 35% of FY'03 disbursements. Therefore, the assessment was calculated with a $6 million reduction to the Special Fund Budget, and no reduction to the Private Trust Fund Budget.

SPECIAL FUND:	**FY'04 Estimated Year End Balance**	**35% of FY'03 Expenditures**	**Amount of Reduction Required**
	$14,000,942	$7,810,950	$6,189,992

PRIVATE TRUST FUND:	**FY'04 Estimated Year End Balance**	**35% of FY'03 Expenditures**	**Amount of Reduction Required**
	$6,790,658	$16,853,200	$0

4. CONVERSION TO RATIO:

Expenditures, income, and any balance adjustment, must be converted to a ratio. This is calculated by dividing each of the first three steps by the assessment base, which represents losses paid during Calendar Year 2003. For the Private Fund, the assessment base is $791.7M.

Private Expenditure Ratio:	10.507%	($83.2 million/$791.7 million)
Projected Income Ratio:	0.757%	($ 6.0 million/$791.7 million)
Balance Adjustment Ratio:	0.781%	($ 6.2 million/$791.7 million)

5. CALCULATION OF THE ASSESSMENT RATIO: 8.968%

After the projected expenditures, income and balance adjustments are converted to ratios, the last two items are subtracted from the expected expenditure ratio to calculate an assessment ratio.

Projected expenditures -	Projected income -	Balance adjustment =	**Assessment Ratio**
10.507%	0.757%	0.781%	**8.969%**

6. CALCULATION OF THE ASSESSMENT RATE: 4.913%

Since the assessment ratio is relative to paid losses, the ratio must be converted into a rate that is relative to projected premiums. This is done by multiplying the assessment ratio by an assessment base factor which represents a ratio of losses to premiums (based on information provided by the WCRIBM). The 2005 assessment base factor is .548.

Assessment Ratio x	Assessment Base Factor =	**Assessment Rate**
8.969%	.548	**4.913%**

DIA OPERATING BUDGET

Legislative Appropriations, Fiscal Year 2005

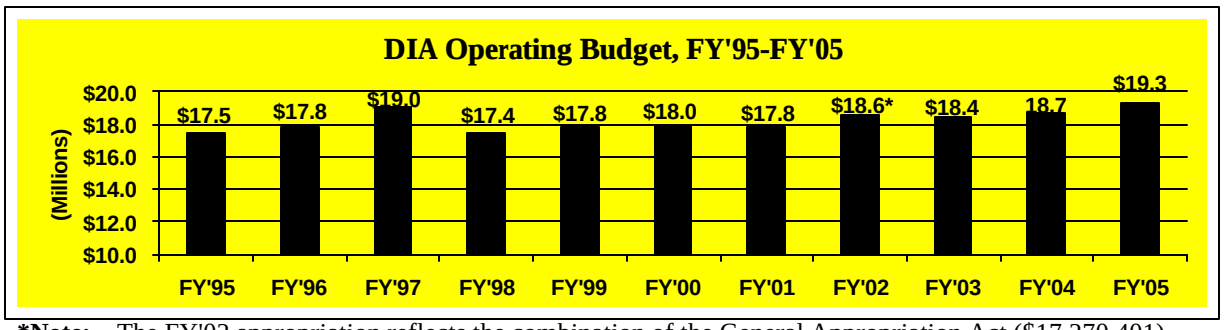
The Division of Industrial Accidents initially requested a budget of $18,698,357 for fiscal year 2005. In House 1, the Governor's recommendation for the DIA's budget was $19,422,377 ($724,020 more than the DIA's original request). The House of Representatives approved a budget of $18,764,222 and the Senate approved appropriations totaling $19,422,377. The final conference committee resolution appropriated $19,335,439 to the DIA, $637,082 more than the agency's original request.

Table 21: Legislative Budget Process for DIA Line-Item, Fiscal Year 2004 - Fiscal Year 2005

Fiscal Year 2004 Budget Process		Fiscal Year 2005 Budget Process	
DIA Request	$18,382,631	DIA Request	$18,698,357
Governor's Rec.	$18,772,922	Governor's Rec.	$19,422,377
Full House	$17,862,495	Full House	$18,764,222
Full Senate	$18,548,357	Full Senate	$19,422,377
Conference Committee	$18,698,357	Conference Committee	$19,335,439
Gen. Appropriations Act	$18,698,357	Gen. Appropriations Act	$19,335,439

General Appropriations Act

On June 25, 2004, Governor Romney signed the FY'05 General Appropriations Act which allocated the DIA a $19,335,439 operating budget. The FY'05 appropriation is only $86,938 less than the Governor's Recommendation (House 1) which was endorsed by the Advisory Council in April of 2004. This appropriation represents a 3.4% increase from last year's final appropriation. Provisions contained within the DIA's appropriation require that "not less than" $800,000 be expended for occupational safety grants and that a judge be assigned to hear cases in Berkshire County "not less than once a month." Furthermore, the line-item contains a provision allowing the Advisory Council to release sufficient funds from the Special Reserve Account to pay for expenses "to continue expansion of the conversion of the agency's computer system from unify to oracle."



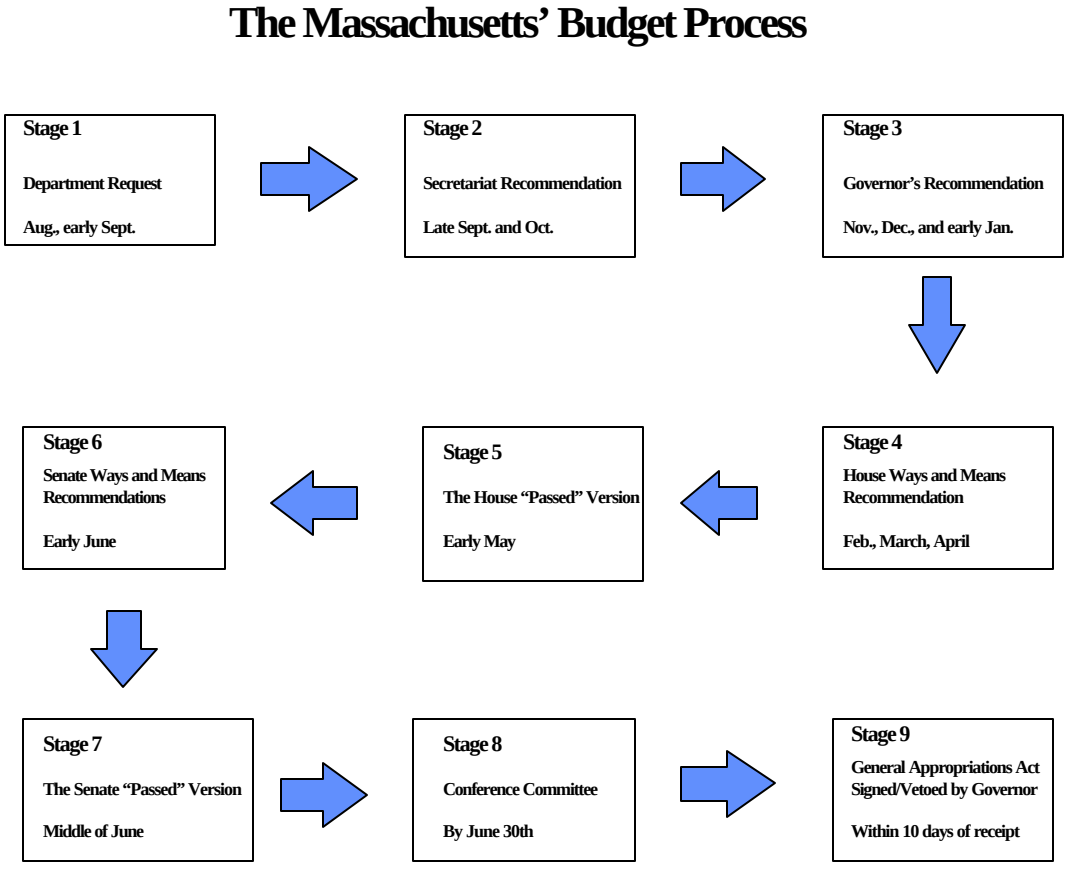
***Note:** The FY'02 appropriation reflects the combination of the General Appropriation Act ($17,270,401) and the Supplemental Budget figures ($1,327,147).

The Budget Process

The operating budget of the DIA must be appropriated by the Legislature even though employer assessments fund the agency. The Division, therefore, must abide by the budget process in the same manner as most other government agencies. It is helpful to view this process in nine distinct phases.[28]

The following is a brief description of the process:

Figure 19: The Massachusetts' Budget Process



[28] Making and Managing the Budget in the Commonwealth of Massachusetts, Donahue Institute for Government Services, University of Massachusetts.

STAGE #1: Department Request

Time Frame: August and Early September

Each department submits a budget for the next fiscal year and a spending plan for the current fiscal year to the Budget Bureau.

STAGE #2: Secretariat Recommendation

Time Frame: Late September and October

The Secretariats analyze each department's requests and meet with department heads to further review respective budgets. Each Secretary will then make their recommendations for the budget.

STAGE #3: Governor's Recommendation (House 1)

Time Frame: November, December, and 1st weeks of January

The Governor's recommendation must be the first bill submitted to the House of Representatives each calendar year. On the fourth Wednesday in January, copies of House 1 are distributed to members of the House and Senate, the Executive Secretaries and department heads, the media, and to any other interested parties. The Governor's recommended budget must be balanced and include all revenue accounts and all expenditure accounts.

STAGE #4: House Ways and Means Committee Recommendations

Time Frame: February, March, and April

House 1 is referred to the House Ways and Means Committee where each line item is analyzed. Public hearings are held in which testimony is taken from the Governor's staff, executive secretariats, departments, and any other interested parties. In April, a new version of the budget replaces House 1 and is traditionally given the label of House 5600.

STAGE #5: The House "Passed" Version

Time Frame: Early May

The members of the House of Representatives take over by subjecting each line item in the budget to debate and amendments. The full House votes to pass a new version of the budget, traditionally known as House 5700.

STAGE #6: Senate Ways and Means Committee Recommendations

Time Frame: Early June

House 5700 is referred to the Senate Ways and Means Committee where hearings and testimony are held. Typically by early June, a recommendation will be published and given to members of the Senate and interested parties. The Chairperson and members of the Committee will hold a press conference to address concerns with this new version of the budget.

STAGE #7: The Senate "Passed" Version

Time Frame: Middle of June

The full Senate reviews each line item and section and subjects them to debate and amendment. Members of the Senate will then vote to pass the new, updated budget.

STAGE #8: Conference Committee

Time Frame: By June 30th

A Conference Committee is created in an effort to resolve differences between the House passed version of the budget and the Senate version. Members of this committee include the chair of both Ways and Means Committees and ranking minority party members from both committees. The only budget information the Conference Committee can analyze is what survived from the House and Senate debates. Compromises are made on each line item by selecting either the budget amount from the House version, the Senate version, or a number in between the two versions. Finally, a new draft is created that both the House and Senate must ratify. If one branch does not ratify the budget, it is sent back to Conference Committee for more work. Once the budget is ratified, it is signed by the Speaker of the House and the President of the Senate. (An interim budget can be enacted by the legislature if the budget is late to allow the government to continue spending while the General Appropriation Act is being finished.)

STAGE #9: General Appropriations Act

Time Frame: Within 10 days of receipt

The Governor has 10 calendar days to decide his position on the budget. During this period, the Governor may both sign the budget and approve as complete; veto selected line items (reduce to zero) but approve and sign the rest; or partially veto (reduce to a lower number) selected line items and approve and sign the rest. The Legislature has the power to override a Governor's veto by a 2/3 vote in both chambers.

SECTION
- 6 -
INSURANCE COVERAGE

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MANDATORY INSURANCE COVERAGE

Every private sector employer in the Commonwealth is required to maintain workers' compensation insurance.[29] Coverage may consist of purchasing a commercial insurance policy, membership in a self-insurance group, participation in a reciprocal insurance exchange, or maintaining a license as a self-insured employer. [30]

All Commonwealth of Massachusetts employees are covered under the Workers' Compensation Act, with claims paid directly from the General Fund. The Executive Office of Administration & Finance, Human Resources Division administers workers' compensation claims, with individual agencies paying a yearly "charge-back" based on losses paid in the prior year. This charge-back comes directly from each agency's operating budget.

When enacted in 1911, the Workers' Compensation Act was elective for counties, cities, towns, and school districts. The majority of municipal employees are covered, with only a few communities having never adopted coverage for certain employee groups. Municipalities attain insurance coverage in a manner identical to private employers (commercial insurance, self-insurance, or membership in a self-insurance group). [31]

The Office of Investigations at the DIA monitors employers in the state to ensure no employer operates without insurance. The office may issue fines and close any business operating without coverage.[32] If an employee is injured while working for a company without coverage, a claim may be filed with the DIA's Trust Fund.[33]

Exemption of Corporate Officers

On July 25, 2002, a new law went into effect that made the requirement of obtaining workers' compensation insurance elective for corporate officers (or the director of a corporation) who own at least 25% of the issued and outstanding stock of that corporation. Said corporate officer must provide the Commissioner of the DIA with a written waiver of their rights should they choose to opt-out from the workers' compensation system.[34] The policies and procedures surrounding the exemption of a corporate officer or director are governed by 452 CMR 8.06 et.seq. The new law also amended the definition of an employee by giving a sole-proprietor or a partnership the ability to be considered an "employee" so they can obtain coverage under a workers' compensation insurance policy.

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[29] This mandate includes sole proprietors that are incorporated, domestics and seasonal workers that average over 16 hours of work a week, and family businesses employing family members. There are certain categories of workers for whom insurance is not required. Seamen, some professional athletes, and unincorporated sole proprietors are exempt.

[30] A reciprocal exchange is a group of employers from diverse industries who pool their funds to insure themselves. An exchange is not self insurance or a self insurance group, but a way to provide commercial insurance to small and medium sized companies without resorting to the residual market.

[31] For more information of the coverage of public employees see Report to the Legislature on Public Employees, Massachusetts Workers' Compensation Advisory Council, 1989.

[32] See section covering Office of Investigations.

[33] See section covering Trust Fund.

[34] Form 153 - "Affidavit of Exemption for Certain Corporate Officers."

COMMERCIAL INSURANCE

Purchasing a commercial insurance policy is the most common method of complying with the workers' compensation mandate. These policies are governed by the provisions of M.G.L. c.152, and are regulated by the Division of Insurance (DOI). The Workers' Compensation Rating & Inspection Bureau of Massachusetts (WCRIBM) has delegated authority to determine standard policy terms, classifications, and manual rates, in addition to maintaining statistics on behalf of the Commissioner of Insurance.

While commercial insurance policies are available that provide for varying degrees of risk retention (such as small and large deductibles), the most common type is first dollar coverage, whereby all losses are paid from the first dollar incurred for medical care and indemnity payments. A variety of pricing mechanisms are also available (including retrospective rating and dividend plans), with the most common being guaranteed cost. In exchange for payment of an annual premium based on rates approved each year by the Commissioner of Insurance, an employer is guaranteed that work related injuries and illnesses will be paid in full by the insurer.

The WCRIBM's Massachusetts Workers' Compensation and Employers Liability Insurance Manual sets forth the methods to determine the classification of insureds as well as terms of policies, premium calculations, credits and deductibles.

The Insurance Market

The commercial insurance market is the primary source of funding for workers' compensation benefits in Massachusetts. A healthy insurance market, therefore, is essential to the welfare of both employees and employers.

Commercial insurance carriers are regulated by the DOI, which provides licensing, monitors solvency, determines rates, approves the terms of policies, and adjudicates unfair claims handling practices. In FY'04, the DOI approved a total of 5 new licenses to carriers to write workers' compensation insurance in Massachusetts. In addition, 4 existing licenses were amended to include workers' compensation. During this same time period, one insurer withdrew their workers' compensation license.

In Massachusetts, workers' compensation insurance rates are determined through an administered pricing system.[35] Insurance rates are proposed by the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIBM) on behalf of the insurance industry, and set by the Commissioner of Insurance. The WCRIBM submits to the Commissioner a classification of risks and premiums, referred to as the rate filing, which is reviewed by the State Rating Bureau. By law, a rate filing must be

[35] In the United States, workers' compensation insurance rates are regulated one of three ways: through administered pricing, competitive rating, or a monopolistic state fund. Administered pricing involves strict regulation of rates by the state. Competitive rating allows carriers to set rates individually, usually based on market-wide losses developed by a rating organization and approved by the state. Monopolistic state funds require that workers' compensation insurance be purchased exclusively through a program run by the state. Some states have competitive state funds that allow employers to purchase insurance from either a private carrier or the state.

submitted at least every two years, and no classifications or premiums may take effect until approved by the Commissioner.[36]

According to the Workers' Compensation Act, the Commissioner of Insurance must conduct a hearing within 60 days of receiving the rate filing, to determine whether the classifications and rates are "not excessive, inadequate or unfairly discriminatory" and that "they fall within a range of reasonableness."[37]

On Friday, August 29, 2003, Insurance Commissioner Julianne Bowler issued a rate decision, which reduced average rates for workers' compensation insurance by **4%** from 2001-2002 rate levels. This rate reduction became effective for policies taking effect on or after September 1, 2003. The only rate increase since 1994 occurred in 2001 when the Insurance Commissioner allowed a 1 percent increase.

During calendar year 2004, workers' compensation insurance rates remained at 2003 levels because there was no rate filing submitted by WCRIBM.

Table 22: Impact of Rate Changes, 1987 - 2004

YEAR	Percent Change from Previous Year's Rate	Assuming a Manual Rate of $100 in 1987
1987	No Change	$100.00
1988	+ 19.9%	$119.90
1989	+ 14.2%	$136.93
1990	+ 26.2%	$172.81
1991	+ 11.3%	$192.34
1992	No Change	$192.34
1993	+ 6.24%	$204.34
1994	- 10.2%	$183.50
1995	- 16.5%	$153.22
1996	- 12.2%	$134.53
1997	No Change	$134.53
1998	- 21.1%	$106.15
1999	- 20.3%	$84.60
2000	No Change	$84.60
2001	+ 1%	$85.44
2002	No Change	$85.44
2003	-4%	$82.03
2004	**No Change**	**$82.03**

The table to the right illustrates the fluctuations in workers' compensation insurance rates since 1987 and how this would effect a company's premium, assuming their premium was $100 in 1987 (with all other factors remaining the same - experience rating, discounts, etc.).

Deviations & Scheduled Credits

The Workers' Compensation Act allows individual carriers to seek permission from the Commissioner to use a percentage decrease from approved rates within certain classifications.[38] These percentage decreases are called "downward deviations." Scheduled credits are also used in Massachusetts as a tool for competitive pricing, by allowing insurers to reward policyholders for good experience. These discounting techniques have become an important part of the Massachusetts insurance market. While open competition is not permitted, the use of deviations (and other alternatively priced policies) has encouraged carriers to compete for business on the basis of pricing.

[36] If the Commissioner takes no action on a rate filing within six months, the rates are then deemed to be approved. If the Commissioner disapproves the rates, a new rate filing may be submitted. Finally, the Commissioner may order a specific rate reduction, if after a hearing it is determined that the current rates are excessive. Determinations by the Commissioner are subject to review by the Supreme Judicial Court.

[37] M.G.L. c.152, §53A(2).

[38] M.G.L. c.152, §53A(9).

In Massachusetts, approximately 33 insurers are currently offering deviations or scheduled credits to their customers. These discounts (some as high as 30%) will remain in effect until the next rate filing.

The Classification System

Workers' compensation insurance rates are calculated and charged to employers, according to industry categories called classifications. Every employer purchasing workers' compensation insurance is assigned a basic classification determined by the nature of its operations. Standard exception classifications may then be assigned for low risk tasks performed within most companies (i.e. clerical work).

Classifications were developed on the theory that the nature, extent and likelihood of certain injuries are common to any given industry. Each classification groups together employers that have a similar exposure to injuries which distributes the overall costs of workers' compensation equitably among employers. Without a classification system, employers in low risk industries would be forced to subsidize high-risk employers through higher insurance costs.

Regulation of Classifications - Classifications in Massachusetts are established by the Workers' Compensation Rating & Inspection Bureau (WCRIBM) subject to approval by the Commissioner of Insurance. Hearings are conducted at the Division of Insurance to determine whether classifications and rates are not excessive, inadequate or unfairly discriminatory and that they fall within a "range of reasonableness."[39]

Basic Classifications - Each business in the Commonwealth is assigned one "basic" classification that best describes the business of the employer. Once a basic classification has been selected, it becomes the company's "governing" classification, the basis for determination of premium.

Although most companies are assigned one governing classification, the following conditions determine when more than one basic classification should be used:

- the basic classification specifically states certain operations to be separately rated;
- the company is engaged in construction or erection operations, farm operations, repair operations, or operates a mercantile business, under which certain conditions allow for additional classifications to be assigned; or
- the company operates more than one business in a state.

Standard Exception Classifications - In addition to the 600 basic classification codes that exist in Massachusetts, there are 4 "standard exception classifications" for those occupations, which are common to virtually every business and pose a decreased risk to worker injury. Employees who fall within the definition of a standard exception classification are not generally included in the basic classification. These low cost

[39] M.G.L. c.152, §53A.

standard exception classifications are: Clerical Office Employees (Code 8810), Drafting Employees (Code 8810), Drivers, Chauffeurs and their Helpers (Code 7380), and Sales-persons, Collectors or Messengers-Outside (Code 8742).

General Inclusions and Exclusions - Sometimes certain operations within a company appear to be a separate business. Most are included, however, within the scope of the governing classification. These operations are called *general inclusions* and are:

- Employee cafeteria operations;
- Manufacture of packing containers;
- Hospital or medical facilities for employees;
- Printing departments; and
- Maintenance or repair work.

Some operations of a business are so unusual that they are separately classified. These operations are called *general exclusions* and are usually classified separately. General exclusions are:

- Aircraft operation - operations involved with flying and ground crews;
- New construction or alterations;
- Stevedoring, including tallying and checking incidental to stevedoring;
- Sawmill operations; and
- Employer-operated day care service.

Manual Rate - Every classification has a corresponding manual rate that is representative of losses sustained by the industry. An employers' base rate is based on manual rate per $100 of payroll, for each governing and standard exception classification.

Class Code	Governing Classification	Manual Rate	Payroll	Base Rate
5188	Automatic Sprinkler Installation & Drivers	$2.50	$200,000	$5,000

Class Code	Standard Exception	Manual Rate	Payroll	Base Rate
8810	Clerical Employees	$.25	$50,000	$125

Appealing a Classification - When a new company applies for insurance, the broker or agent assigns a classification, which is audited by the insurance carrier at the end of the policy year. If the carrier determines the employer or their employees were misclassified, the employer is charged additional premium or receives a credit for the correct class. The WCRIBM is responsible for determining the proper classification for all insureds in Massachusetts. If an employer disagrees with its assigned classification, or believes a separate classification should be created, there is an appeal process made available by M.G.L. c.152, §52D. A formal appeal must be held with the WCRIBM's Governing Committee (for those insured in the Voluntary Market) or the Residual Market Committee (for those insured in the Assigned Risk Pool). The WCRIBM will send an auditor to the worksite and proceed to make a ruling on the classification in question. If reclassification is denied, an appeal can be made to the Commissioner of Insurance. A hearing officer will then be selected by the Commissioner to conduct an evidentiary hearing on the classification issue.

Construction Industry - In the construction industry alone, there are over 67 different classifications for the various types of construction or erection operations. Often, multiple classifications must be assigned to large general contractors who use different trades during the many phases of construction projects. Separate payrolls must be maintained for separate classifications or else a construction company can be assigned to the highest rated classification that applies to the job or location where the operation is performed. The Massachusetts Construction Classification Premium Adjustment Program is a program that provides for a manual premium credit ranging from 5% to 25%, depending on average hourly wages paid to employees. Because a disparity exists between high and low wage construction employers (largely determined by the existence of a collective bargaining agreement), this program is designed to offset the higher premiums associated with larger payrolls and equalize workers' compensation costs.

Premium Calculation

Premiums charged to employers in Massachusetts are dependent on several factors that are designed to measure each company's exposure to loss. Premium is based on uniform rates that are developed for each classification and modified according to the attributes of each employer. In return for payment of premiums, the insurance company will administer all workers' compensation claims and pay all medical, indemnity (weekly compensation), rehabilitation, and supplemental benefits due under the Workers' Compensation Act. The following is an overview of the premium calculation process.

Manual Premium - The first step in the premium calculation process is determination of manual premium. The manual premium is reflective of both the industry (manual rate) and size (payroll) of a company. The manual premium is calculated by multiplying the employer's manual rate by its annual payroll per $100.

Manual Premium = (Manual Rate x Payroll) / 100

An employer's manual rate is assigned according to its classification. As explained in the prior section, every classification has a corresponding manual rate that reflects the industry's exposure to loss.

Once a corresponding manual rate has been established, exposure to loss for the particular employer must then be considered. In Massachusetts, this is determined by payroll. Payroll is a factor of an employers wage rate, the number of employees employed, and the number of hours worked. All other factors being equal, a firm with a large payroll has a greater exposure to loss than a firm with a smaller payroll. Furthermore, since indemnity benefits are calculated as a percentage of wages earned, payroll also reflects severity of potential loss.

Standard Premium - Once a manual premium has been determined, it is then multiplied by an experience modification factor to determine the standard premium.

Standard Premium = Manual Premium x Experience Modification Factor

Experience rating is a system of comparing the claims history of each employer against the average claims experience of all employers within the same classification. An experience modification factor is calculated, which provides either a premium reduction (credit) or a premium increase (debit) to an insured's premium. For example, a modification of .75 results in a 25% credit or savings to the premium, while a modification of 1.10 produces a 10% debit or additional charge to the premium. When a modification of 1.00 (unity) is applied, no change to premium results.

The experience modification factor is determined on an annual basis, which is based on an insured's losses for the last three completed years. For instance, two similar employers may have a manual rate of $25 per $100 of payroll, but the safety conscious employer (with fewer past claims) may have an experience modification factor of .80, thus adjusting his rate to $20 per $100 of payroll. The other employer, who is not as safety conscious, may have an experience modification factor of 1.20, which adjusts the company's rate to $30 per $100 of payroll.

All Risk Adjustment Program - In January 1990, the WCRIBM instituted the All Risk Adjustment Program (ARAP), calculated in addition to the experience modification factor. Its original purpose was to establish adequate premiums to encourage more insurers to write voluntary business. ARAP measures actual losses against expected losses, but it differs from the experience modification in that it measures severity and not frequency of claims. ARAP can add a surcharge up to 49% of an employer's experience modified standard premium.

Premium Discounting

Insurance companies that provide workers' compensation coverage must factor in the various expenses involved with servicing insureds to determine appropriate premium levels. However, a problem occurs when pricing premiums for large policies because as the premium increases, the proportion required to pay expenses decreases. In an effort to compensate for these differences, insurers must provide a premium discount to large policy holders. The premium discount increases as the size of the policy premium increases, resulting in a premium that better reflects costs. In most states, policy holders are entitled to a premium discount if they are paying over $10,000 in premiums.

Table 23: Percent of Premium Discount for Type A & B Companies

TYPE "A" COMPANIES			TYPE "B" COMPANIES		
Layer of Standard Premium		Percent of Premium Discount	Layer of Standard Premium		Percent of Premium Discount
First	10,000	0.0%	First	10,000	0.0%
Next	190,000	9.1%	Next	190,000	5.1%
Next	1,550,000	11.3%	Next	1,550,000	6.5%
Over	1,750,000	12.3%	Over	1,750,000	7.5%

Source: WCRIBM, A General Revision of Workers' Comp. Insurance Rates and Rating Values, pg. 590 (8/14/95).

Deductible Policies

Since 1991, deductible policies can provide the advantages of a retrospective policy and self-insurance. Employers are responsible for paying from the first dollar incurred up to the deductible limit, either on a per claim basis or on an aggregate basis for claims in the policy year. The insurer pays all benefits and then seeks reimbursement from the employer up to the amount of the deductible.

Table 24: Premium Reduction % Per Claim Deductible

PER CLAIM DEDUCTIBLE[40] *Effective May 1, 1996*	
Medical and Indemnity Deductible Amount	**Premium Reduction Percentage**
$ 500	3.0%
$1,000	4.2%
$2,000	6.2%
$2,500	7.1%
$5,000	10.6%

Source: WCRIBM

Table 25: Massachusetts Benefits Claim and Aggregate Deductible Program

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM[41]			
Estimated Annual Standard Premium	**Claim Deductible Amount**	**Aggregate Deductible Amount**	**Premium Reduction Percentage**
0 to $75,000	$2,500	$10,000	7.0%
$75,001 to $100,000	$2,500	$10,000	6.5%
$100,001 to 125,000	$2,500	$10,000	5.9%
$125,001 to $150,000	$2,500	$10,000	5.4%
$150,001 to $200,000	$2,500	$10,000	4.5%
over $200,000	$2,500	5% of Estimated Annual Standard Premium	4.3%

Source: WCRIBM, A General Revision of Workers' Comp. Insurance Rates & Rating Values (8/14/95).

Retrospective Rating Plans

Retrospective rating bases premium on an insured's actual losses calculated at the conclusion of the policy period. Therefore, the insured has greater control over its insurance costs by monitoring and controlling its own losses. Retrospective rating should not be confused with "experience rating." Both adjust premium based on an employer's loss history. Experience rating, however, adjusts premiums at the start of the policy period (to predict future losses), whereas retrospective rating adjusts premiums at the end of the policy period to reflect losses that actually occurred.

The Formula - Although retrospective premiums are determined by a complex formula, they are generally based on three factors: losses the employer incurs during a policy period; expenses that are related to the losses incurred; and basic premium. Incurred losses have historically included medical and indemnity losses, interest on judgments, and expenses incurred in third-party recoveries.[42] A basic premium is necessary to defray the expenses that do not vary with losses and to provide the insurance company with a

[40] Massachusetts Workers' Compensation and Employer's Liability Insurance.
[41] Massachusetts Workers' Compensation and Employer's Liability Insurance.
[42] "Retrospective Rating," Risk Financing, Supplement No. 46, May 1995: III.D.7.

profit. To control the cost of the premium in extreme cases, the policies state that the premium cannot be less than a specific minimum and cannot exceed a stated maximum.

Eligibility Requirements - Eligibility for a retrospective rating plan is based upon a minimum standard premium. Eligibility for a one-year plan is an estimated standard premium of at least $25,000 per year, and for a three-year plan the estimated standard premium must be at least $75,000.[43] Although these eligibility standards exclude many small businesses, one of the biggest misconceptions is that retrospective plans are only for large employers and high-risk groups. In Massachusetts, more smaller employers are purchasing retrospective plans to lower premiums by controlling company losses.

Benefits and Disadvantages - Under the right circumstances, retrospective rating can benefit both the insurer and the policyholder. The policyholder benefits by paying a smaller premium at the beginning of the policy year. Because premium is determined by losses, retrospective plans reward those businesses that maintain effective loss control programs. If losses are low, the insured will pay less than standard premium. However, there is a significant uncertainty regarding the final premium amount, since it is impossible to be precise in predicting the volume or severity of workplace accidents. An unexpected claim towards the end of a policy period can be detrimental to a company, if funds have not been set aside for the retro-premium. Furthermore, there is little incentive for the insurance company to limit settlement costs, when they are able to recover payments made on claims brought against the policyholder.

Dividend Plans

Offered as another means of reducing an employers insurance costs, dividend plans can provide the policy-owner with a partial return on a previously paid premium. This payment from the insurer takes into account investment income, expenses, and the insured's overall loss-experience in a given year. The dividend is usually paid to the insured directly or by applying it to future premiums due. Regardless of how the payment is issued, dividends are non-taxable, since they are considered a return of premium.[44] Dividend plans may seem attractive to policy holders, but sometimes promise more than can be delivered. Insurer's are not legally bound to pay what they may have estimated a policy holder's return to be. Moreover, many insurers strategically calculate a dividend only once between 18 and 24 months after a policy's inception, and not always to the advantage of the insured.[45]

[43] Workers' Compensation: Exposures, Coverage, Claims, Levick, Dwight E. Standard Publishing Corp., page 11-4.
[44] "Risk Management-Life, Health, and Income Exposures," Life Insurance, Part 4: 406.
[45] "Thinking About the Work Comp Crisis," Merrit Risk Management Review, December 1991: 3.

ASSIGNED RISK POOL

Any employer rejected for workers' compensation insurance can obtain coverage through the residual market, known as the Assigned Risk Pool. Administered by the Workers' Compensation Rating and Inspection Bureau (WCRIBM), the Assigned Risk Pool is the "insurer of last resort" and is required by law to provide coverage when an employer is rejected by at least two carriers within five business days. Very small employers and companies in high-risk classifications or having poor experience ratings often cannot obtain insurance in the voluntary market. This occurs when a carrier determines that the cost of providing insurance to a particular company is greater than the premium it can collect.

The estimated ultimate residual market share for the 12-months ending August, 2004 is 19%.[46] Although this percentage has trended upward since 1999, it remains far below the 64.7% of workers' compensation premium share that was in the residual market during the 1992 policy year.

Employers insured through the pool pay standard premium and are not offered premium discounts, dividend plans, etc. The Commissioner of Insurance chooses the carriers that will administer the policies, called "servicing carriers." The servicing carriers are paid a commission for servicing these policies, and are subject to performance standards and a paid loss incentive program. These programs are designed to provide servicing carriers with incentives to provide loss control services to those insured.

Residual Market Loads - Every insurance carrier licensed to write workers' compensation policies is required to be a member of the Assigned Risk Pool. Members are collectively responsible for underwriting pool policies, for bearing the risk of all losses, and are entitled to any profits generated. When the pool operates at a deficit, the members are subject to an assessment. Assessments are calculated in direct proportion to the amount of premium written in the voluntary market. This is called the Residual Market Load.

The Residual Market Load is incorporated into rates and can be a significant factor for employers to search out alternative risk financing options. Self insurance and self-insurance groups are not subject to residual market assessments. The Residual Market Load is incorporated into manual rates. This residual market burden (percentage of each voluntary market dollar used to pay for the assigned risk pool) has significantly increased over the past five years. The residual market loss ratio measures the amount of losses and expenses to the premiums written (roughly money out divided by money in). A loss ratio greater than 100% indicates that losses are greater than revenues (premiums). The estimated (as of 9/03) residual market loss ratio for Policy Year 2002 is 83.0% with a resulting residual market burden of 5.4%.[47]

[46] WCRIBM Special Bulletin No. 11-04 (October 29, 2003).
[47] WCRIBM Special Bulletin No. 03-04 (April 2, 2004).

ALTERNATIVE RISK FINANCING METHODS

Self insurance and self insurance groups (SIGs) became an extremely popular device to control rising workers' compensation costs, when insurance rates rose dramatically in the late 1980's and early 1990's. Much of the cost savings derived from avoidance of residual market loads incorporated into commercial insurance premiums to pay for the large assigned risk pool. Since 1993, insurance rates have decreased dramatically, making alternative risk financing measures less attractive. In recent years, employers have re-assessed cost savings associated with these programs, and many have turned to commercial insurance plans, (large deductible policies and retrospective rating plans).

Self Insurance

The DIA strictly regulates self insured employers through its annual licensing procedures. For an employer to qualify to become self insured, it must post a surety bond of at least $100,000 to cover for losses that may occur (452 C.M.R. 5:00). This amount varies for every company depending on their previous reported losses and predicted future losses. The average bond, however, is usually over $1 million. Self insurance is generally available to larger employers with at least 300 employees and $750,000 in annual standard premium.[48] These regulations may be waived by the Commissioner of the DIA for employers that have strong safety records and can produce the necessary bond to cover incurred losses. In addition, employers who are self insured must purchase reinsurance of at least $500,000. Each self-insured employer may administer its own claims or engage the services of a law firm or a third party administrator (TPA) to handle claims administration. The Office of Insurance evaluates employers every year to determine their continued eligibility and to set bond amounts.

Figure 20: Self Insurance in MA - Premium Dollars

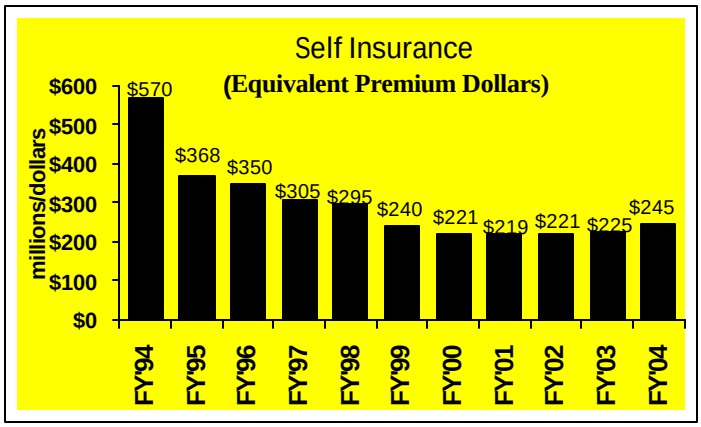


Table 26: Total Self-insured licenses in Massachusetts

	New Licenses	Total Licenses	Companies Covered
FY'04	1	129	380
FY'03	2	143	445
FY'02	2	139	478
FY'01	3	151	419
FY'00	5	173	437
FY'99	6	174	464
FY'98	5	186	503
FY'97	5	206	417
FY'96	5	226	734
FY'95	11	227	734
FY'94	23	224	688

Source: DIA Office of Insurance

[48] 452 C.M.R. 5.00: Code of Massachusetts Regulations concerning insurers and self insurers.

Self Insurance Groups

Companies in related industries may join forces to form a self insurance group (SIG). Regulated by the Division of Insurance, SIGs may include public employers, non-profit groups, and private employers in the same industry or trade association.[49]

As part of the workers' compensation reform package of 1985, SIGs were permitted in Massachusetts to provide an alternative to coverage in the assigned risk pool. Since that time, membership has been a popular alternative to commercial insurance because of the ability for members to manage their own claims. In addition, SIGs are generally able to reduce administrative costs from a fully insured plan. These savings result from reduced or eliminated commissions, premium taxes, etc.

Table 27: Membership in W/C SIGs as of Jan. 1st

Membership in Workers' Compensation Self-Insurance Groups as of Jan. 1st

Year	Number of Groups	Number of Members
1991	8	N/A
1992	21	N/A
1993	28	N/A
1994	27	2,300
1995	31	2,550
1996	32	2,700
1997	30	2,830
1998	26	2,880
1999	25	2,821
2000	24	Unavailable
2001	25	Unavailable
2002	25	3,000
2003	24	3,456
2004	24	3,768

Members of a self insurance group are assigned a classification and are charged manual rates approved by the Commissioner of Insurance for commercial insurance policies. Premium is calculated in the same manner, with manual rates adjusted by an experience modification factor and the All Risk Adjustment Program (ARAP).[50] Cost savings arise through dividends returned to members and deviated rates.

Companies who join self insurance groups rely heavily on the solvency and safety records of fellow members, since the insurance risks are spread amongst the group. If one of the employers in a group declares bankruptcy or suffers a catastrophic accident, the whole group must absorb the losses. In addition, all members share joint and several liability for losses incurred.

The first group was approved in 1987. After a few years of modest interest, eight SIGs were formed in 1991 and 21 in 1992. As of January 1, 2004, Massachusetts had 24 SIGs with 3,768 members.

[49] According to Division of Insurance regulations, a SIG must have "five or more employers who are engaged in the same or similar type of business, who are members of the same bona fide industry, trade or professional association which has been in existence for not less than two years, or who are parties to the same or related collective bargaining agreements. (Div. of Insurance Regulations, 211 CMR 67.02).

[50] 211 CMR 67.09.

INSURANCE FRAUD BUREAU

The Insurance Fraud Bureau (IFB) is an insurance industry supported agency authorized by the Commonwealth to detect, prevent and refer for criminal prosecution suspected fraudulent insurance transactions involving all lines of insurance. [51] It was created in 1990 to investigate auto insurance fraud and expanded in 1991 to include workers' compensation fraud.[52] While its mission statement is to include all lines of insurance, the focus is on automobile and workers' compensation insurance.

IFB Funding

The IFB receives half of its annually budgeted operating revenues from the Automobile Insurers Bureau (AIB) and half from the Workers' Compensation Rating and Inspection Bureau (WCRIB). In 2003, each of these bureaus contributed a total of $2,730,825 to fund the IFB. The 2003 operating expenses for the IFB totaled $5,362,834, a $192,611 decrease (-3.5%) over 2002 expense levels. Due to actual operating expenses being less than what was budgeted for, the IFB returned the net surplus of $124,674 back to the AIB and WCRIB in early 2004.

The Investigative Process

Referrals - Cases of suspected fraud for all types of insurance are generally referred to the IFB, either through an insurance carrier or through a toll-free hotline, which can be reached at: 800-32-FRAUD. In calendar year 2003, the IFB received 363 referrals regarding workers' compensation fraud.[53] Of these referrals, 65 (18%) were accepted for investigation.

Evaluation - Once a referral is received by the IFB, an investigative staff must evaluate each case within 20 working days. During this time, status letters are sent to the insurance companies indicating whether the case was referred to another agency or accepted for further investigation. A backlog has historically existed in investigations at this initial stage.

Assigned Cases - Once resources become available, a referral is assigned to an investigator and officially becomes a "case." In calendar year 2003, a total of 53 "new" cases were assigned to investigators dealing with workers' compensation fraud and 142 cases were investigated during the year.

[51] The Insurance Fraud Bureau has its own Internet web site which can be found at http://www.ifb.org. The site is designed to inform the public on the activities and accomplishments of the IFB. The site also allows the general public to submit anonymous tips on suspected insurance fraud.

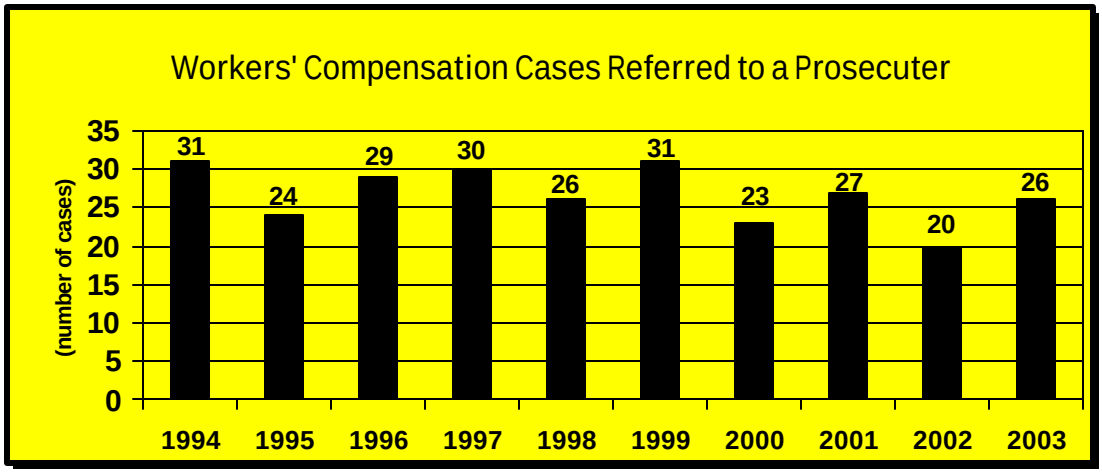
[52] M.G.L. St. 1990, c.338 as amended by St. 1991, c.398, §9

[53] Solicited referrals are included in this number.

Prosecution

After an investigator has completed their work on a case, it is either referred to a prosecutor (primarily the Massachusetts Attorney General's Office), transferred to another agency, or closed due to lack of evidence. In calendar year 2003, a total of 26 cases were referred to a prosecutor dealing with workers' compensation fraud.

Figure 21: Workers' Compensation Cases Referred to a Prosecutor



Source: 2003 Insurance Fraud Bureau Annual Report

The types of workers' compensation cases that are investigated vary greatly. Fraud can be perpetrated by the employee, employer, medical provider, attorney and in some cases the insurance agent. The majority of IFB investigations, however, involve employee misconduct. IFB personnel primarily investigate the following types of workers' compensation fraud:

- *Claimants with duplicate identities who worked while receiving workers' compensation benefits or who earned income from one or more employers and failed to disclose it;*
- *Cases in which the subject staged an on-the-job accident;*
- *Cases where subjects participated in physical activities wholly inconsistent with the disability claimed or whose injuries were fraudulently attributed to the workplace;*
- *Premium evasion fraud and phony death claims.*

While fraud continues to be a major concern for everyone involved in workers' compensation, the IFB and the Attorney General's Office continue to make great strides in curtailing this crime. It is difficult to establish criminal intent in fraud cases, but the pursuit of these cases and publicizing any convictions will establish a precedent warning to those who consider defrauding the workers' compensation system, that fraud will not be tolerated.